



# **Massachusetts Sexual Violence Prevention Plan**

**2009-2016**

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March, 2009

Dear Stakeholder:

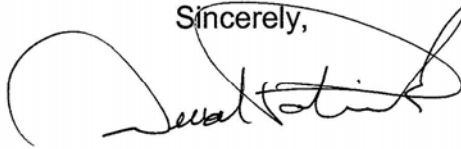
It is with great hope that I present the *Massachusetts Sexual Violence Prevention Plan*. This plan was developed by the Massachusetts State Prevention Team, a multidisciplinary and diverse group of community-based and state prevention professionals, through the stewardship of the Department of Public Health (DPH) and Jane Doe Inc., the Massachusetts Coalition Against Sexual Assault and Domestic Violence, and the financial and technical support of the U.S. Centers for Disease Control and Prevention. The plan is based in careful analysis of national, state, and local data sources, which include not only relevant numbers and formal research, but also the vital knowledge and experience of community stakeholders. The breadth of data examined and included in the report has guided the State Prevention Team's targeted selection of promising sexual violence prevention strategies.

This report is unique in its vision of a progressive approach to preventing sexual violence perpetration before it occurs, as a necessary complement to equally essential services to assist survivors, stop abusers from re-offending, and raise awareness. With its focus on primary prevention, this report outlines a concrete plan to keep children from developing problem sexual behaviors, help parents and educators teach children that sexual respect is expected, and assist adults in changing the climates in our diverse communities

and institutions so that healthy relationships between all people can be the state norm.

I hope that this report will be a guide for state and local leaders, as we continue not only to improve our responses to incidents of sexual violence, but also toward shaping a safer, healthier future for all.

Sincerely,

A handwritten signature in black ink, appearing to read "D. J. [unclear]", written over the word "Sincerely,".

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## EXECUTIVE SUMMARY

If you know someone who has been hurt sexually or who has hurt someone sexually—imagine how life could be different if that hurt had simply never happened. Imagine what Massachusetts would be like without individual, family, and community suffering from the higher PTSD, suicide, substance abuse, and STD rates associated with sexual assault. Imagine our state no longer needing to spend more than \$183,000 per sexual assault incident on medical and mental health care, police response, prosecution, incarceration, and decreased productivity (1). Imagine a Commonwealth in which healthy sexuality and sexual respect are the norm: one in which relationships are respectful and mutual, based on equality and open communications, and where healthy sexuality is safe and inclusive of diverse cultures, disabilities, gender identities, sexual orientations and ages. Imagine a Commonwealth where families, communities, and institutions create and sustain environments that promote healthy relationships and healthy constructions of sexuality and gender. This is our vision for sexual violence prevention, a future for Massachusetts that we can create together.

Massachusetts is proud of the many pioneering ways our communities have addressed the daunting public health issue of sexual violence. Volunteer activists in our state created some of the first rape crisis centers in the country, and were among the first to secure state funds to help support these essential services. Many innovations have followed, including Massachusetts' history of prevention leadership. This leadership has been built from community organizing, and is well-connected with national research and resources, such as the Violence Against Women Act-based Rape Prevention Education Program.

Massachusetts is now poised to take the next step in our collective work toward ending sexual violence in the Commonwealth. Together, we will deepen our primary prevention focus and our coordinated planning, implementation, and evaluation of prevention strategies and outcomes. Many stakeholders and communities throughout our state have already begun to build their capacity to engage in this important work.

In 2005, Massachusetts was one of only 4 states funded by the U.S. Centers for Disease Control with an EMPOWER grant to create an effective and realistic 5 - 8 year statewide plan for the primary prevention of sexual violence. The Department of Public Health (DPH), in partnership with Jane Doe Inc.: The Massachusetts Coalition Against Sexual and Domestic Violence, convened a diverse State Prevention Team (SPT) to conduct this strategic planning process, described in Section II of the plan document. This government-coalition partnership reflects the roots of the sexual and domestic violence movements. These movements began not just as social services, but as social justice movements that demanded real change and real results. Our efforts will capitalize on other grassroots-government partnership successes, such as anti-drunk driving and smoking reduction initiatives. These initiatives succeeded because they had the sustained support of government public health and safety agencies and community organizing advocacy groups.

With broad stakeholder input, the SPT developed a vision and corresponding focus populations and goals. The goals were developed using community and empirical data, with

an awareness that we could not plan to reach all Massachusetts residents within 5-8 years with our existing resources. Therefore, the plan focuses on a population with higher perpetration risk (i.e., males); groups with higher victimization risk/burden (i.e., youth, people with developmental disabilities and GLBT communities); and certain systems with the readiness to engage in primary prevention, (e.g., sexual and domestic violence programs). The data, assets, challenges, risk and protective factors, and system readiness that we examined in developing plan priorities are contained in Section III of the plan document.

Throughout this planning process, we worked to understand and incorporate “evidence-informed” prevention principles, which are fundamental to effective public health prevention. Because this plan is based on what is known about what works, and on our unique past and present circumstances in Massachusetts, we believe that it is realistic and achievable plan for the timeline we have set. Further, we are committed to continuing to refine the plan as we move forward with its implementation. The goals for implementation of the plan, found in Section IV, are:

- Support the promotion of healthy constructions of masculinity for males across the lifespan.
- Engage parents and child care, school, campus, and other youth organizations, including those serving youth with disabilities, to implement policies and practices that promote respectful, consensual relationships and healthy sexuality.
- Enhance provider systems’ capacities to support healthy sexuality and relationships for people with developmental disabilities.
- Expand data and provider trainings for a wide range of public health programs in order to increase their engagement in the prevention of sexual violence against gay, lesbian, bisexual and transgender populations.
- Encourage communities to identify and define their own key elements of SV prevention.
- Build upon the Jane Doe - DPH partnership to expand capacity of sexual and domestic violence programs so that they may become leaders in effective prevention.

It is important to note that this primary prevention plan is intended to be one component of a comprehensive response to sexual violence. Prevention strategies recommended in this plan will not replace the need for competent services for survivors and people who have sexually abused, nor do they replace the need for awareness, risk reduction, empowerment programs, and effective supervision and enforcement. The plan emphasizes the importance of “trauma-informed” prevention strategies with the hope that they will supplement these other important services. Moreover, we note that participants in our primary prevention strategies will undoubtedly include some people who have experienced sexual abuse or abused, but have not been identified as victims or abusers.

Strategies in this plan also address oppressions like heterosexism, racism, sexism, and ableism, in which sexual and domestic violence are rooted. Our strategies are also intended to be adapted so that they are culturally-specific. Evidence suggests that “one size fits all” approaches to prevention programming tend to be less effective, so the development of culturally-specific strategies will be undertaken in partnership with and by people who have borne a disproportionate burden of sexual violence and been historically underserved.

The SPT will continue to work as an ongoing, collaborative, multidisciplinary group in order to support ongoing statewide coordination and accountability. This work will build upon the strengths and leadership of those who have been doing this work for many years. In the next several years, the SPT will develop an evaluation plan, identify ways of more fully integrating sexual and domestic violence prevention approaches, and support implementation improvement and sustainability.

This plan is intended to help people and systems focus on what the evidence reveals about sexually abusive behavior (i.e., who does it, how they do it, and what the environmental risk and protective factors are). It prioritizes real opportunities to cultivate environments that will reduce the chances anyone would choose to harm others in the first place. State agencies and community stakeholders are encouraged to collaborate with the SPT to ensure an effective, coordinated approach. In doing so, we can all learn about effective approaches to prevention that “fit” our respective roles within a cohesive prevention system. Each of us has a role in supporting healthy relationships and sexuality in our own homes, communities, workplaces, and practices. When we engage in truly coordinated, and effective prevention efforts, our work will lead us closer to a Massachusetts where everyone has the opportunity to experience healthy relationships and sexual respect.

## **II. Introduction**

### **FORWARD: THE SIGNIFICANCE OF THIS PLAN**

The SPT developed its ambitious yet realistic plan for the direction of sexual violence prevention based on complementary factors: the unique context of sexual violence and prevention capacity within the state; and the guidelines, tools, and feedback provided by the CDC and its national partners in the EMPOWER project. The SPT sought to create a plan tailored to our state’s existing systems, organizations, populations, and structures. We also wanted to enhance the current capacity to deliver sexual violence prevention in a high-quality and efficient manner, with a particular focus on reducing the disparate impact on groups that have borne a disproportionate burden of sexual violence.

The MA Sexual Violence Prevention Plan suggests opportunities for prevention with populations previously disconnected from statewide SV prevention systems. It also steers the expansion and coordination of current SV prevention systems into more focused, and wherever possible, more evidence-informed directions.

We, the members of the SPT, are proud to offer this plan to all who live, work, visit, and study in the Commonwealth. The creation of a coordinated state plan for the primary prevention of sexual violence is a monumental step forward. For decades, rape crisis center advocates and their allies have worked tirelessly to provide urgently needed services to survivors of sexual assault and their families, friends, and associates. We have taken great strides towards making Massachusetts a safe place. However, we have known that focusing exclusively on responding to survivors in the immediate or long-term aftermath of sexual

violence was not enough to stop it from happening. Educating the public about sexual violence became a priority, as did finding ways to prevent sexual violence from occurring in the first place. While we recognized the importance of preventing sexual violence, we often lacked important tools that were needed to do so effectively.

This statewide plan represents the culmination of a three year planning process, and several years of pre-planning work. We have attempted to be thorough, thoughtful, and above all, responsible to our obligation to serve the residents of our state with integrity. There were times when reaching consensus about priorities, ideas, and strategies was challenging. We were conscious that our decision-making would affect the direction of sexual violence prevention in the Commonwealth. We therefore attempted to consider each piece of data, and each suggestion, from multiple viewpoints. Underlying our work together was a shared vision of safety, respect, and wellness.

The MA plan for sexual violence prevention identifies key areas for specialized prevention capacity-building and programming over the next 5-8 years. Given the limitations of current funding and capacity, not every aspect of sexual violence prevention can be addressed immediately or completely. It will take time to demonstrate results even in the key areas identified in this plan.

Once changes have been made in policy and practice, it will be essential to analyze the results for fidelity to planning, fidelity to programming, adaptation to local community conditions, and effectiveness in reducing sexual violence or increasing the protective factors that guard against sexually violent behavior development. As these results are examined, program improvements can be made, and effective efforts can be replicated and adapted to other communities. Planning will therefore be an ongoing process, and in the future we will have opportunities to address emerging needs and opportunities in sexual violence prevention.

The MA Sexual Violence Prevention Plan is both ambitious and achievable. However, the success of the plan depends upon the dedicated leadership of many at the state and community levels. Prior public health campaigns, such as those to reduce smoking and drunk driving, have required ample time and the participation of many in order to succeed. Our plan to prevent sexual violence will also take a sustained commitment, but we are confident that over time we will be able to reduce sexual violence in the Commonwealth.

## **STATE PREVENTION TEAM (SPT) HISTORY, RECRUITMENT, MEMBERSHIP & PROCESS**

In January 2006, the Massachusetts Sexual Violence State Prevention Team (SPT) was convened by the Massachusetts Department of Public Health (MDPH) in partnership with Jane Doe Inc: The Massachusetts Coalition Against Sexual and Domestic Violence. The SPT was formed following the establishment of a cooperative agreement between the MDPH and the U.S. Centers for Disease Control and Prevention (CDC), which MDPH won through a highly competitive process. The cooperative agreement is called EMPOWER (Enhancing



and Making Programs and Outcomes Work to End Rape). The purpose of the EMPOWER program was two-fold; [1] to build statewide capacity for comprehensive planning and evaluation of sexual violence primary prevention activities in Massachusetts, and [2] to create a statewide plan for the primary prevention of sexual violence. These efforts built upon previous violence prevention strategic planning in Massachusetts. The resulting prevention plan (*i.e.*, this report) will inform the Rape Prevention and Education (RPE) grant and state sexual violence prevention funding decisions, build capacity of state agencies and local providers to prevent sexual violence, and guide policy development. Ultimately, we anticipate that it will decrease the incidence of sexual violence in the Commonwealth.

### *The History of the Massachusetts SPT*

In 2005 the CDC released the EMPOWER grant solicitation. This request for proposals invited state departments of public health to assemble planning teams (State Prevention Teams) that would, collaborate on the development of a state plan for the primary prevention of sexual assault. The process was to utilize the “Getting to Outcomes” (GTO) framework<sup>1</sup>, and the CDC specified that members of the SPT should include stakeholders and representatives of Massachusetts subpopulations necessary for the development of a relevant, useful plan. These included rape crisis center personnel, representatives of state agencies, and individuals who could advocate for ethnic and racial subpopulations. The MDPH responded with a proposal to establish a 12-member SPT that included: representatives of MDPH, the state coalition against domestic and sexual violence (Jane Doe, Inc.), the Governor’s Commission to Address Domestic and Sexual Violence, the Massachusetts Executive Office of Public Safety, the Wellesley College Centers for Women, the Disabled Persons Protection Commission, the Boston Area Campus Sexual Assault Coalition, the Massachusetts Coalition of Sex Offender Management, the Massachusetts Child Sexual Abuse Prevention Partnership, an expert consultant in perpetration prevention previously with the national organization Stop It Now!, and three local rape crisis center RPE grantees. Massachusetts was awarded one of the four CDC EMPOWER cooperative agreements, and thus in February of 2006 held its first SPT meeting. The SPT met 4-6 times per year during the award period (2006-2008). In addition, multiple additional SPT subcommittee and stakeholder meetings were conducted by members during this period.

### *Recruitment of SPT members*

SPT members were recruited via personal outreach by three members of the EMPOWER State Capacity Building Team (SCBT): Mark Bergeron-Naper of MDPH, Marci Diamond of MDPH, and Debra Robbin of Jane Doe, Inc. Each of these three SCBT members had held professional positions in sexual violence prevention in Massachusetts for eight or more years, and as a result, had many associates and contacts across sectors in the Commonwealth upon which they could draw. The SCBT reviewed the original list of proposed SPT members and jointly identified additional agencies and subpopulations that they felt should be represented on the SPT. They made direct calls to individuals whom they felt would be well-suited for and interested in SPT participation in order to explain what the planning process

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<sup>1</sup> Getting To Outcomes is an approach that can be used to plan, implement, and evaluate prevention strategies in order to improve outcomes. It has been used to plan several public health initiatives previously.

would entail. With few exceptions, invited individuals agreed to join the SPT. During the course of the award period, some SPT members dropped out or were replaced because of personnel changes at their agencies or shifts in job responsibilities. Each of these membership changes were carefully considered by the SCBT and additions were agreed upon via a consensus process.

Invited members signed Memoranda of Understanding (MOUs) with Jane Doe, Inc., that specified their roles and responsibilities before joining the SPT. In most cases, members' agencies received stipends (ranging from \$500-\$2000 per year) supported by the EMPOWER cooperative agreement, to offset the costs of participating in SPT meetings and activities. State agencies (i.e., MDPH, the Massachusetts Executive Office of Public Safety, the Disabled Persons Protection Commission) were not reimbursed for their employees' involvement in the SPT.

Based on what was known about our state's demographics, the magnitude of sexual violence (SV), and our state prevention systems, the SCBT prioritized particular community sectors for SPT member recruitment. These sectors included the Spanish-speaking population, the gay, lesbian, bisexual, and transgender (GLBT) population, people with disabilities, men, immigrants and refugees, and the college population. In addition, the SCBT felt that it was critical to include representatives of agencies that would likely be involved in providing resources to implement the plan and/or had prior experience with similar planning initiatives, such as the MDPH Healthy Sexuality workgroup, the Massachusetts Coalition of Sex Offender Management, youth violence prevention initiatives, individuals with experience in primary prevention and behavior change strategies from the MDPH HIV/AIDS Bureau, and the Governor's Commission to Address Domestic and Sexual Violence. Thus, many individuals on the SPT simultaneously occupied more than one identity or representation role. For example, an individual representing a particular agency may also have had a role with a statewide coalition and/or one or more personal identities (e.g., person of color, person with a disability, male) that had also been prioritized.

#### *List of SPT Members*

<b>NAME</b>	<b>AGENCY</b>
Marci Diamond	MDPH- Sexual Assault Prevention and Survivor Services
Debra Robbin	Jane Doe Inc: MA Coalition Against Sexual & Domestic Violence
Emily Rothman (EE)	Boston University School of Public Health
Quynh Dang	MDPH- Refugee and Immigrant Safety and Empowerment
Mark Bergeron-Naper	MDPH- Sexual Assault Prevention and Survivor Services
Aimee Thompson	Close to Home: Growing Strong Communities to Prevent DV
Sheridan Haines	Governor's Council to Address Sexual and Domestic Violence
Craig Norberg-Bohm	Jane Doe Inc: MA Coalition Against Sexual & Domestic Violence
Janice Mirabassi	MDPH- Sexual Assault Prevention and Survivor Services
Gina Scaramella	Boston Area Rape Crisis Center
Becky Lockwood	University of Massachusetts, Amherst/Everywoman's Center
Sabrina Santiago	The Network/La Red: Ending Abuse in LBW&T Communities

Susan Love	Disabled Person's Protection Commission
Gordon Braxton	Harvard College, Office Sexual Assault Prevention & Response
Joan Tabachnick	DSM Consulting/MASOC/MATSA
Barry Callis	MDPH- HIV/AIDS Prevention
Neil Maniar	MDPH- Youth Violence Prevention Program

### *Previous SPT members*

<b>NAME</b>	<b>AGENCY</b>
Christine Brown	SMOC, Voices Against Violence Program
Zenaida Burgos	Llámanos: Statewide Spanish-Language SV Helpline
Marilee Kenney-Hunt	Governor's Commission on Sexual and Domestic Violence
Susan Marine	Harvard College, Office Sexual Assault Prevention & Response
Andres Polanco	YWCA of Greater Lawrence, Haverhill Youth Violence Coalition
Megan Lewis-Freedman	MA Child Abuse Prevention Partnership/MA Citizens for Children
Nan Stein	Wellesley University
Paula Tessier	MDPH- Safe Spaces for GLBT Youth
Eric Tucker	Boston Public Health Commission- Father Friendly Initiative

Additional thanks for plan contributions from (affiliations listed for identification only): Paula Potvin (DMR), Denise Roy (RCCCM), Chris Palames, Laura Rauscher, Carlene Pavlos (DPH), Jan O'Keefe (DMR), Nancy Altiero (DPPC), Allyson Baughman (BU), and many others.

### *SPT Processes*

In keeping with CDC requirements, the SPT's development of this state prevention plan was guided by the Getting to Outcomes (GTO) framework and reflected Empowerment Evaluation (EE) Principles. The 10 steps of GTO (Table 1) and 10 Empowerment Evaluation Principles (Table 2) are listed below. Further, the SPT used a consensus decision-making process for key choices (such as prioritizing selected populations), and completed the tasks associated with this project in small, collaborative workgroups. For example, workgroups comprising SPT members contributed to the completion of GTO Step 1 (a state needs and resources assessment) and GTO Step 2 (developing goals and objectives). In total, SPT members participated actively in quarterly SPT meetings, periodic (i.e., biweekly) conference calls between SPT meetings, and in workgroup assignments (as needed). There was some variation in members' level of engagement in these processes. In addition, SPT members were subscribed to a Massachusetts EMPOWER email list, maintained by the SPT coordinator, which was used to send monthly (or more frequent) updates and materials to SPT members. The processes described reflected EE principles in that they involved broad dialogues which allowed for debate, encouraged equal participation from all members, permitted all members to be heard and to have their points of view incorporated into end products, valued their community knowledge and reflected their diversity. Moreover, SPT

members were learning as they undertook the work associated with completing each step of GTO; thus, building their own individual capabilities, the capacity of their agencies, and the state prevention system.

**Table 1 Steps of GTO**

1. Needs and resources
2. Goals and desired outcomes
3. Evidence-based practice
4. Fit
5. Capacity
6. Plan
7. Process evaluation
8. Outcome evaluation
9. Continuous quality improvement
10. Sustainability

## **Table 2 Principles of Empowerment Evaluation**

1. Improvement
2. Community Ownership
3. Inclusion
4. Democratic Ownership
5. Social Justice
6. Evidence-based Practice
7. Community Knowledge
8. Capacity Building
9. Organizational Learning
10. Accountability

## **PURPOSE OF SV PREVENTION PLAN**

The purpose of this plan is to provide Massachusetts with a “roadmap” to use over the next five to eight years to reduce the burden of sexual violence in the Commonwealth and expand our state systems’ capacities to address this and other forms of interpersonal violence. The plan makes clear our selection of populations and strategies, and our rationales for these selections. The plan also presents the context for our decisions, including our shared vision for healthy relationships and sexual respect, definitions of important terms, and our assessment of Massachusetts’ needs and strengths with regard to sexual violence prevention.

## **Sexual Violence Vision Statement**

Healthy relationships and sexual respect define our vision for preventing sexual violence against all people in Massachusetts.

The working principles that informed the development of our goals are:

- 1) Healthy interpersonal relationships will be respectful, mutual, and based on equality and open communications.
- 2) Sexual respect will be based in responsible constructions of masculinity, femininity, and gender. Healthy sexuality<sup>2</sup> will be safe and joyful, foster connection, honor boundaries, respect developmental stages, and be inclusive of diverse cultures, disabilities, gender identities, sexual orientations, and ages.
- 3) Sexual violence is any sexual activity where consent is not obtained or able to be freely given (see complete definition below)

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<sup>2</sup> See also Surgeon General’s *Call to Action to Promote Sexual Health and Responsible Sexual Behavior* (2001), *SEICUS Guidelines for Comprehensive Sexuality Education* (2004) <http://www.siecus.org/pubs/guidelines/guidelines.pdf>, et al.

- 4) Communities will be sustainably engaged in sharing accountability for everyone's well-being, remaining vigilant in transforming historical oppressions. Community and state efforts to prevent sexual violence must include coordination with sexual violence survivor and offender services.

## **Sexual Violence Definition**

(incorporates the CDC's definition; MA additions in italics)

**Sexual violence is any sexual activity where consent is not obtained or able to be freely given.**

The SPT definition of SV includes a continuum of behaviors ranging from sexual assault involving penetration to non-contact sexual abuse such as verbal and behavioral sexual harassment. We believe that it would be inappropriate to remove non-contact sexual abuse (as defined below) from the SV definition. While non-contact sexual abuse is not always included in SV surveys or surveillance, CDC believes it is important to recognize and measure the full range of sexual violence.

*When discussing what sexual violence “is,” the MA SPT believes that certain social norms and policies which serve to perpetuate sexual violence could also be seen as sexual violence against entire communities and populations. The SPT therefore plans to explore strategies that address “sexually violent” social norms and policies when the SPT develops its statewide plan for sexual violence prevention. However, for the purposes of our definition of what constitutes “incidents of sexual violence”, we will focus on what individual victims experience.*

The term ‘sexual violence’ (SV) is used to demonstrate a broad continuum of sexually violent and abusive behaviors that includes – but is not limited to – rape, sexual assault, drug facilitated sexual assault, and sexual harassment *and exploitation. It is also not limited to criminally sanctionable behaviors.*

The definition of SV used in this report is adapted from Sexual Violence Surveillance: Uniform Definitions and Recommended Data Elements (7) published by the Centers for Disease Control and Prevention (CDC). Sexual violence can be perpetrated by current or former intimate partners, family members, persons in a position of power or trust (e.g., *faith leaders, caregivers, medical providers, teachers, etc., who may also be violating professional ethical standards*), friend/acquaintances, non-strangers and strangers. Current and former intimate partners may be *lesbian, gay, bisexual, transgender, or heterosexual* and include current or former spouses (including common-law) and non-marital partners (including boyfriend and girlfriend relationships). Victims may be women, men, *transgender individuals* or children. *Perpetrators may be juveniles or adults.* Perpetrators and victims may be of the same or opposite sex.

The CDC's overall definition of SV is as follows: “Nonconsensual completed or attempted contact between the penis and the vulva or the penis and the anus involving penetration,

however slight; nonconsensual contact between the mouth and the penis, vulva, or anus; nonconsensual penetration of the anal or genital opening of another person by a hand, finger, or other object; nonconsensual intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks; or nonconsensual non-contact acts of a sexual nature such as voyeurism and verbal or behavioral sexual harassment. All the above acts also qualify as sexual violence if they are committed against someone who is unable to consent or refuse” (7).

The *SPT*’s definition of SV includes the following types of violence (adapted from Basile and Saltzman, 2002):

1. A completed sex act without the victim’s consent, *when a victim has withdrawn prior consent*, or involving a victim who is unable to consent or refuse. A victim is unable to consent or refuse due to age, illness, disability, being asleep or under the influence of alcohol or other drugs.
2. An attempted (non-completed) sex act without the victim’s consent, *when a victim has withdrawn prior consent* or involving a victim who is unable to consent or refuse.
3. Abusive sexual contact which is defined as intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person without his or her consent, *or forcing another person who does not consent to touch one’s own genitalia, anus, groin, breast, inner thigh, or buttocks*, or such activities with a person who is unable to consent or refuse, *or has withdrawn prior consent*.
4. Non-contact sexual abuse/exploitation. *This includes acts such as on-line solicitation of minors by adults; unwelcome on-line solicitation of adults; voyeurism; intentional exposure of an individual to exhibitionism; pornography; verbal or behavioral sexual harassment; threats of sexual violence to accomplish some other end; taking nude photographs of a sexual nature of another person without his or her consent or knowledge, when a victim has withdrawn prior consent, or of a person who is unable to consent or refuse; and all use and distribution (including but not limited to internet use and distribution) of child pornography*).

More detailed information on CDC’s definitions of SV can be accessed at:

[http://www.cdc.gov/ncipc/pub-res/ipv\\_surveillance/Intimate%20Partner%20Violence.pdf](http://www.cdc.gov/ncipc/pub-res/ipv_surveillance/Intimate%20Partner%20Violence.pdf)  
and [http://www.cdc.gov/ncipc/pub-res/sv\\_surveillance/SexViolSurv.pdf](http://www.cdc.gov/ncipc/pub-res/sv_surveillance/SexViolSurv.pdf) .

### **III. Needs and Resources Assessment Summary**

#### **State Profile**

Understanding Massachusetts' needs and resources related to the primary prevention of sexual violence was essential to effective statewide planning, and served as the foundation for subsequent steps in the planning process.

There is a wealth of information regarding sexual violence in Massachusetts. A summary of this information is provided here. However, many gaps in knowledge exist, particularly regarding marginalized communities and the primary prevention of perpetration. The SPT engaged in data collection with professionals and community members regarding SV prevention assets, but it was beyond the SPT's capacity to collect new surveillance data for this assessment. The gaps and limitations in the information that we found are noted below with the hope that they may be addressed in the future.

## **Demographic, Economic and Social Profile**

[Source: 2000 U.S. Census unless otherwise indicated]

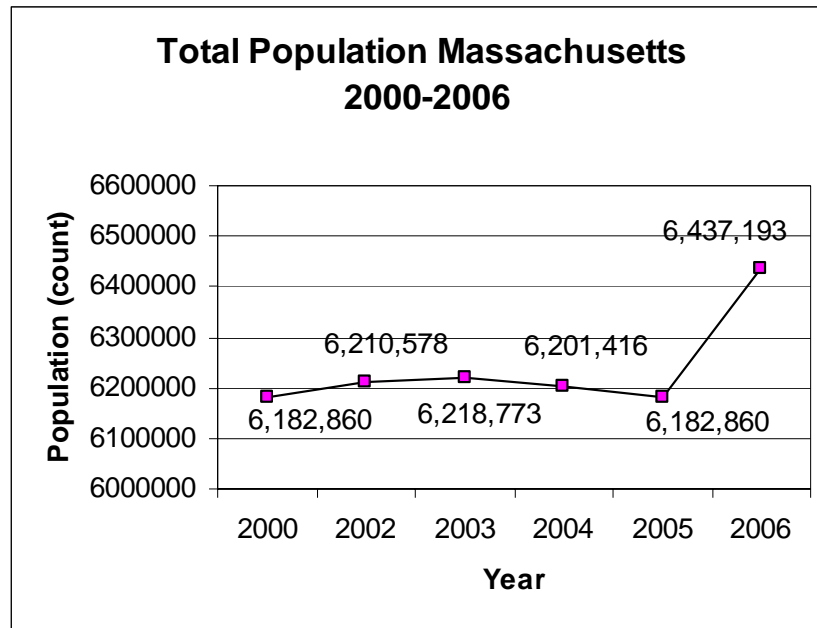
The Commonwealth of Massachusetts is a relatively small state of 7,840 square miles located in the Northeastern region of the U.S.



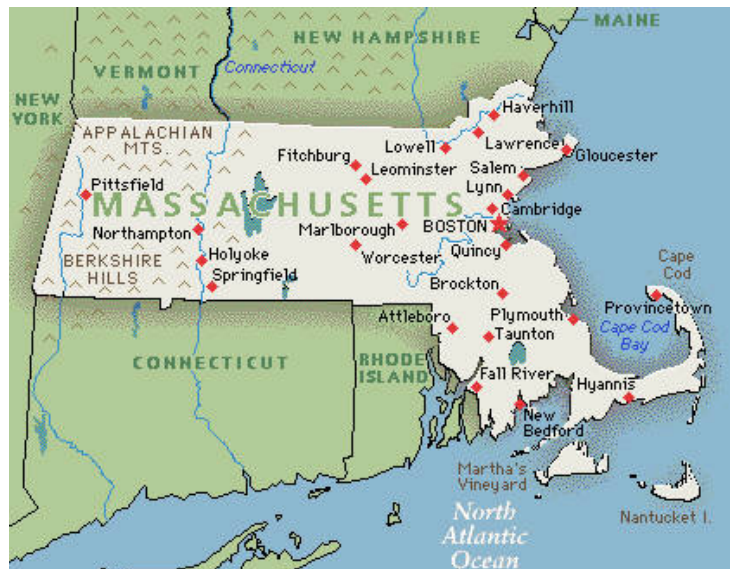
According to the 2000 Census, the total population of Massachusetts is 6,182,860. Since then, the state has slowly been increasing in population (see Table 3).

**Table 3**





The capital of Massachusetts is Boston, which has a population of close to 600,000 residents. The ten largest cities in Massachusetts are distributed in every region of the state: Boston, Worcester, Springfield, Lowell, Cambridge, Brockton, New Bedford, Fall River, Lynn, and Quincy. Massachusetts is a very urban state with only 16% of its land classified as rural (7). According to the Metropolitan Area Planning Council, the suburban communities along I-495 are the fastest growing communities in the state.



## Gender

Table 4 describes the distribution of gender in Massachusetts (9). The proportion of females is slightly higher than that of males. No data has been found for the state, or any geographic area, concerning transgender populations or citizens who have undergone sexual reassignment. These special populations are at disproportionate risk for sexual violence and more data about this population is needed.

**Table 4: Distribution of Gender in Massachusetts**

	<u>Number</u>	<u>%</u>
Female:	3,184,822	51.5
Male:	2,998,038	48.5
Female to Male	<i>missing</i>	N/A
Male to Female	<i>missing</i>	N/A
Transgender	<i>missing</i>	N/A

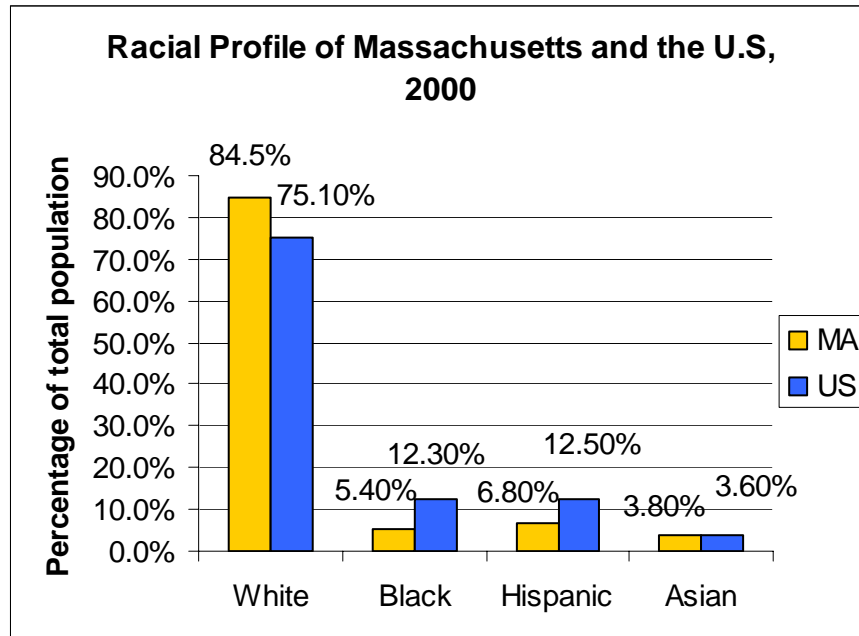
## Age

The age distribution of Massachusetts' residents is similar to that of U.S. residents overall. Children age 4 or younger account for 6% of the population while 13% are between the ages of 5-14 years, 12% are between 15-24 years, 57% are between 25-64 years old, and 11% are age 65 or older. Currently, one in five Massachusetts residents is age 55 or older. It is estimated that by the year 2030, one in three will be in this age group (9).

## Race and Ethnicity

Table 5 compares the racial demographics of Massachusetts and the U.S.

**Table 5**



In terms of racial identity, the majority of Massachusetts residents describe themselves as White. State-wide, 7% identify as Hispanic, 5% Black, 4% Asian, 0.2% American Indian/Native, and 4% identify as another race. Currently, approximately 18% of Massachusetts residents self-identify as people of color. By the year 2030, this proportion is projected to rise to 31% (9).

### Nativity and Language

In 2006, 14% of the people living in Massachusetts were foreign born. Among people at least five years old, 20% spoke a primary language other than English. Of those speaking another language at home, 34% spoke Spanish; 43% of people reported that they did not speak English “very well.”

In the public school system, 14% of students report that their primary language is not English; these students reside in all regions of the state, with varied distribution by specific languages. With the exception of Watertown, MA, where Armenian is the most commonly spoken language in the public schools, the most common languages spoken by students, with the cities/towns that have the highest populations of these students are shown in Table 6 (10):

**Table 6 Languages spoken in Massachusetts’ Public Schools**

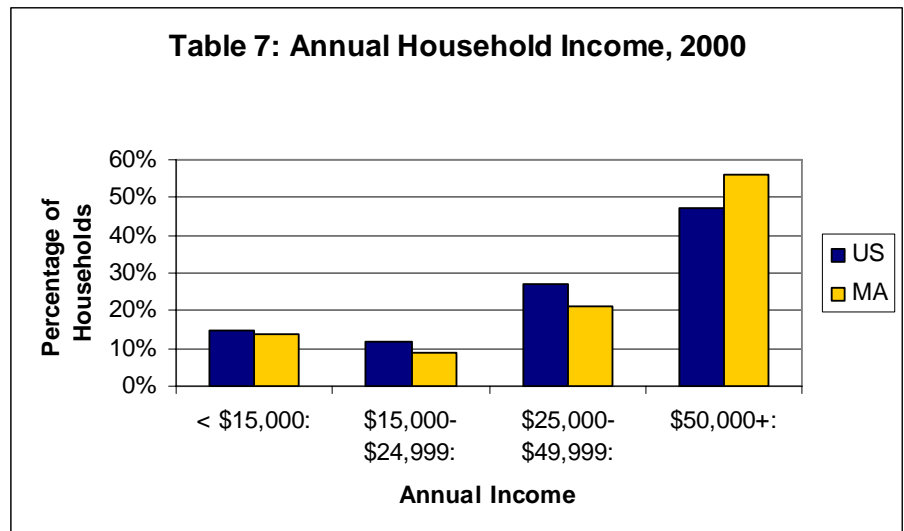
Primary Language (not including English)	City/Town
Spanish	Amherst, Attleboro, Boston, Cambridge, Chelsea, Chicopee, Clinton, Everett, Fitchburg, Framingham, Haverhill, Holyoke, Lawrence, Leominster, Lynn, Methuen, New Bedford, Salem, Somerville, Southbridge, Springfield,

	Waltham, and Worcester
Portuguese	Fall River, Marlborough, Medford, Milford, and Peabody
Chinese	Acton, Belmont, Lexington, Malden, Newton, and Quincy
Khmer	Lowell
Haitian Creole	Randolph
Cape Verdean	Brockton
Russian	Brookline, Westfield, West Springfield
Arabic	Norwood

Vietnamese and Korean are also in the top 10 language groups spoken by students in Massachusetts

## Income

Compared to the population of the United States, Massachusetts residents tend to be slightly wealthier. In 2000, the median income of households in Massachusetts was \$57,184; in the U.S it was \$48,451. The average annual income in the state is \$31,000 per individual per year compared to a U.S. average of \$25,000 per individual per year. Massachusetts also has fewer families living below the poverty level than the U.S. average (7.3% versus 10%, respectively).



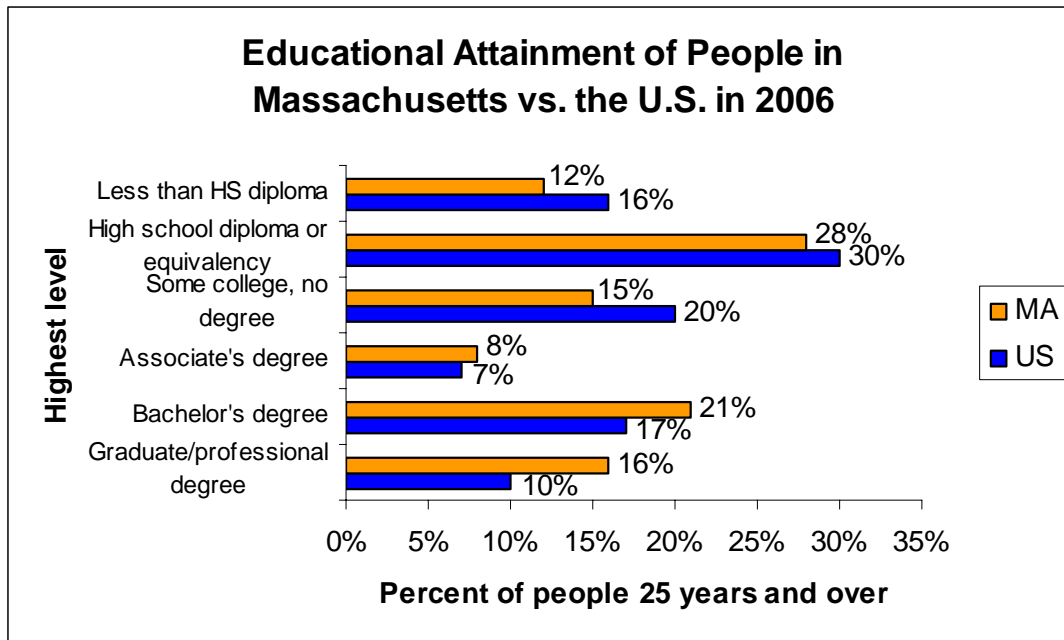
2006, Massachusetts median household income: \$59,963

2006, U.S. median household income: \$48,451

## Education

Approximately 60% of Massachusetts residents have at least some college education, which is slightly higher than for U.S. residents on the whole (54%). The Massachusetts Department of Education estimates that 19% of the Massachusetts adults are not functionally literate. There are 280,091 undergraduate and 118,051 graduate college students in Massachusetts (11). Table 8 describes the educational attainment of Massachusetts' residents in 2006.

**Table 8**



The unemployment rate in Massachusetts is slightly higher (5.1%) than it is in the U.S. (4.6%).

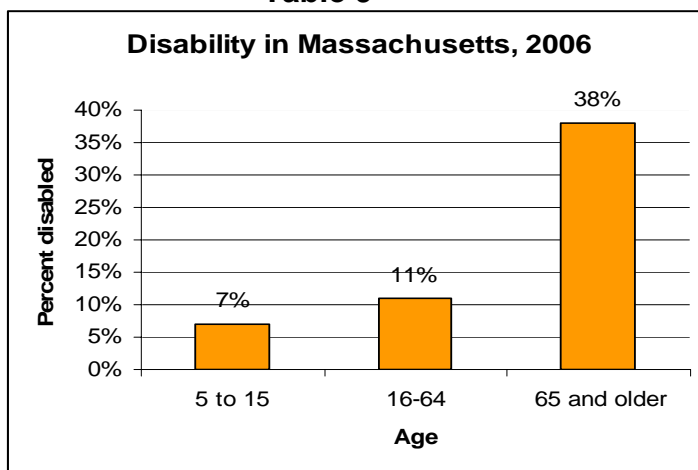
### **Sexual Orientation**

Until 2008, Massachusetts was the only state in the U.S. where same-sex marriages were legal. Of the 75,507 marriages that took place in MA between 2004-2006 (MDPH Data), 16,342 (22%) were between same-sex couples. According to sexual orientation data collected by the 2005 Massachusetts Behavioral Risk Factor Surveillance Survey, 3.3% of Massachusetts residents self-identified as gay, lesbian, bisexual or non-heterosexual (12).

## People with Disabilities<sup>+</sup>

According to data from the 2006 American Community Survey, over 746,000 people in Massachusetts (14% of the population age 5 years old or older) have a disability (13). The likelihood of having a disability varies by age in the state, from 7% of people age 5 to 15 years old, 11% of people 16 to 64 years old, and 38% of those 65 years and older.

**Table 9**



## Specific Marginalized Populations

Roughly 11,000 people in Massachusetts are homeless (0.2% of the total population, (8)), and almost 23,000 are incarcerated, including unconvicted inmates (0.4% of the total population, Bureau of Justice Statistics, 2006). According to the Massachusetts Department of Public Health, the state has 50,794 nursing home beds (62.7 per 1000 people age 65+).

## Circumstances in Massachusetts that Impact the Primary Prevention of Sexual Violence (SV)

The following list highlights the past, current, and future circumstances in Massachusetts that may impact the ability of the state to support the primary prevention of sexual violence (SV).

- **Widespread visibility of sexual abuse by clergy and other leaders within the Catholic Church.** News about sexual abuse and its concealment within the largest religious institution in the state illustrated the weakness of community sanctions, and led to increased survivor

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<sup>+</sup> The American Community Survey determines disability from the following: Blindness, deafness, or a severe vision or hearing impairment; a condition that substantially limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting, or carrying; a physical, mental, or emotional condition lasting 6 months or more with the person having difficulty: learning, remembering, concentrating, dressing, bathing, getting around inside the home, going outside the home alone to shop or visit a doctor's office, or working at a job or business.

organizing. It also increased awareness of sexual assault prevention as an institutional and community change issue.

- **Other high profile sexual violence cases.** These have created teachable moments and fostered dialogue in communities about sexual violence and how communities can respond effectively.

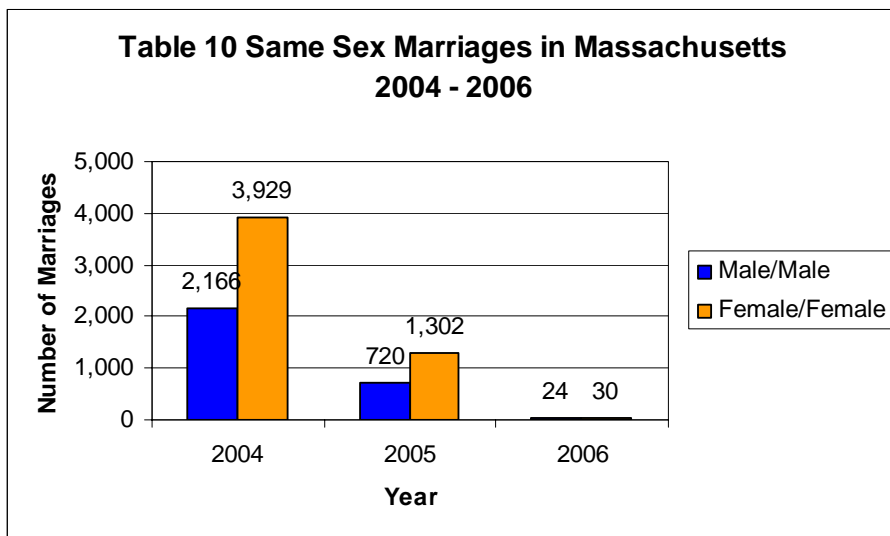
- **Legalization of Gay Marriage.** Currently, Massachusetts is the only state where same-sex marriage is explicitly legal. This challenges traditional gender roles, supports GLBT visibility, and creates opportunities to address the intersections of homophobia and the primary prevention of sexual violence.

- **2006 Gubernatorial campaign.**

The campaign explicitly raised issues of sexual violence myths and stereotypes. Massachusetts now has the only (and second ever) African-American governor in the United States (Governor Deval Patrick), a long term “out” gay member of Congress (Rep. Barney Frank-D), and a female Attorney General (Martha Coakley), representing a diversity of people in publicly elected offices in the state.

- **New governor and state administration supportive of prevention and public health.** In 2007, the new state administration proposed budget increases to public health and refused federal abstinence-only education funding in favor of more comprehensive evidence-based approaches to public health.

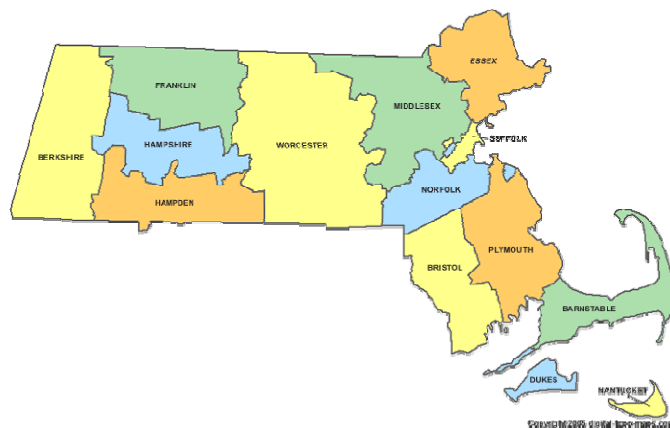
- **Comprehensive health education in schools initiative.** In 2006, a coalition of stakeholders began to coalesce to pursue legislation requiring school-based comprehensive health education including healthy sexuality/relationship education, which could provide immense opportunities for sexual violence prevention in the next 5-8 years.



## Other Circumstances to Consider

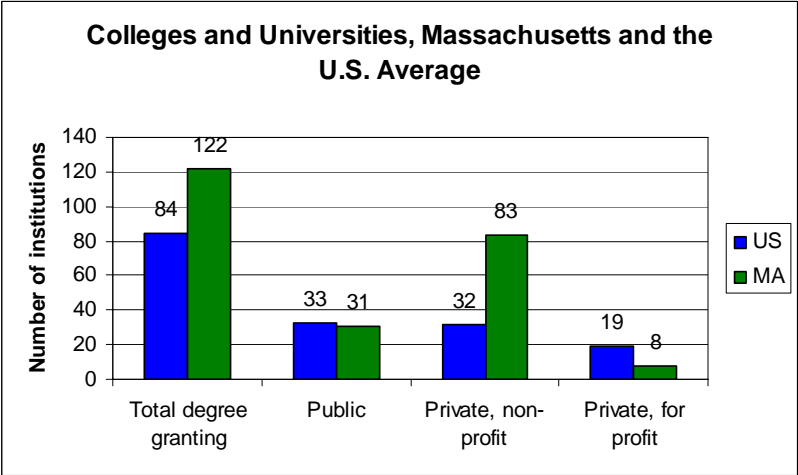
- **Lack of county-level government.** Although Massachusetts is divided into 14 counties, county-level government is basically limited to criminal justice/corrections (sheriffs) and judicial (district attorneys/courts) systems. Massachusetts does not currently have county-based health departments or other services with one exception (Barnstable County Department of Health and Human Services). Thus, county government is not a primary base for prevention services as it is in many other states.

- **Large college-age population.**



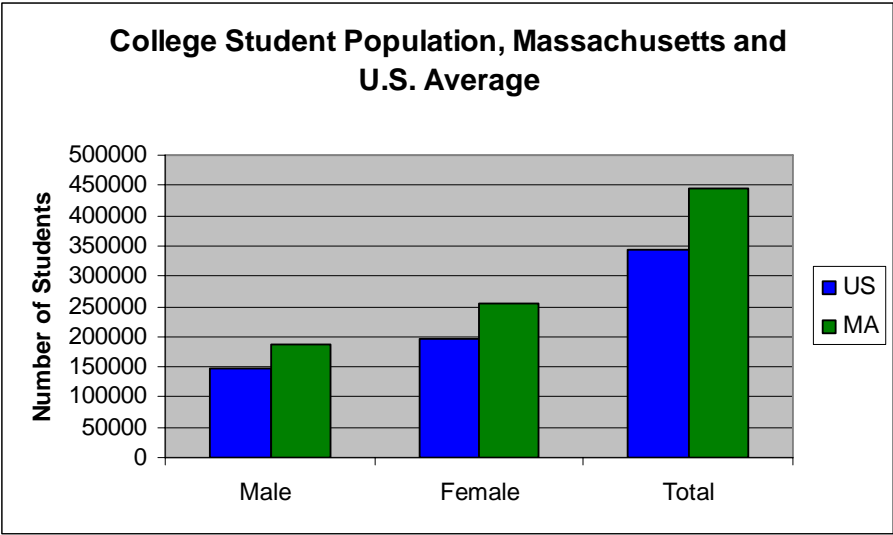
According to the National Center for Education Statistics, Massachusetts has 122 degree-granting institutions, 30% more than the U.S. average. Massachusetts also has more than twice the national average number of private, non-profit colleges and universities (see Table 11 below). Given these statistics, a focus on college populations is particularly important in Massachusetts and provides unique challenges and opportunities for prevention.

**Table 11**



The college-age population in the state is substantially larger than the U.S. average (Table 12). This holds true for male and female students, but the difference is greater for female students.

**Table 12**



## The Magnitude of Sexual Violence

This section presents the prevalence of sexual violence victimization among Massachusetts residents. Prior to presenting the data, we first discuss limitations of our data collection systems in order to facilitate interpretation. Readers will appreciate the challenges



associated with obtaining accurate information about sexual violence, intimate partner violence, and child sexual abuse in the lives of Massachusetts residents.

### **The limits of our data**

- We believe that sexual violence, intimate partner violence and child sexual abuse victimization and perpetration are underreported on self-report surveys. Therefore, estimates derived from surveillance systems that rely on self-reported data are believed to be underestimates.
- Some agencies and institutions whose primary mission is to respond to individuals in crisis prioritize the safe provision of services over data collection accuracy; therefore, data obtained from these agencies and institutions may be incomplete and may contain inaccuracies.
- Data collected by crisis response agencies from individuals who are experiencing acute trauma may be less complete than data collected from individuals in less emotionally charged situations. At the same time, there is a possibility that data collected from individuals who are recalling traumatic experiences that occurred in the more distant past may be less accurate than details recalled by those who have just experienced such an incident.
- Where efforts to collect data on a statewide basis have participation from only some providers within that system, bias may be inherent and the value of the data collected may be diminished

Source: Governor's Commission on Sexual and Domestic Violence: Summaries of Statewide Data Sources Relevant to Sexual and Domestic Violence and Child Sexual Abuse, 2005.

### **Global context**

According to the World Health Organization “the true extent of sexual violence is unknown” (14). In part, this is due to variations in how “sexual violence” is defined across studies, and variations in data collection and analysis methods used. There are also significant gaps in research that keep sexual violence invisible and off of policymakers’ agendas (15).

Despite limitations of the existing body of knowledge about sexual violence, the WHO Report confirms what many advocates have observed: sexual violence terrorizes women, men, girls, and boys across the globe.

The following facts help demonstrate the pervasiveness of sexual violence:

- Nearly one in four women may experience sexual violence by an intimate partner in her lifetime (14).

- The practice of marrying off children as young as seven or eight is not uncommon. Forced marriage brings with it forced sexual initiation for children (14).
- Findings from international studies show that 20% of women report a history of childhood sexual abuse (16).
- Evidence suggests that males may be even less likely than females to report sexual assaults to authorities due to shame, guilt, fear of not being believed or of being denounced (14).
- Currently and formerly incarcerated men widely report rape by fellow inmates, prison officials, and police in many countries (14).

Source: The National Sexual Violence Resource Center's Global Perspectives on Sexual Violence: Findings from the World Report on Violence and Health, 2004.

### **National-level data**

Several population based studies have been conducted in the U.S. from which it is possible to estimate the lifetime prevalence of sexual violence victimization. The National Women's Study (NWS), conducted from 1990-1992, found that the lifetime prevalence of SV for women was 12.5% (17). Similarly, the National Violence Against Women Survey (NVAWS) found that 14.8% of women and 2.1% of men report being victims of rape in their lifetimes (6). The second Injury Control and Risk Survey (ICARIS-2), which was implemented 2001-2003, found that 10.6% and 2.1% of women and men, respectively, reported ever experiencing forced sex (18). The ICARIS-2 investigators reported that discrepancies between their estimates and those from the NVAWS may be attributable to differences in the definition and measurement of sexual violence.

We were not able to identify any population-based surveys from which it is possible to estimate the prevalence of sexual violence victimization among transgender people. The results of one community-based convenience sample survey suggest that 18% of transgender respondents had experienced sexual assault, and 23% had experienced sexual harassment, at some time in their lives (19).

It is now widely understood that a substantial proportion of sexual violence victims are children. The NVAWS found that 54% of female sexual assault victims were under 18 at the time of the assault (22% were younger than 12 years old, and 32% were between 12 and 17 years old), and 71% of male rape victims were raped before age 18 (48% were younger than 12 years old, and 23% were between age 12 and 17 years old) (6). These findings are consistent with those from the ICARIS-2 study, which found that 60% of female, and 69% of male, rape victims were raped before they were 18 years old.

National data indicate that individuals with disabilities are more likely than the general population to experience sexual assault victimization. A recent study by the CDC found that women with a disability were significantly more likely than women without a disability to report

experiencing some form of intimate partner violence in their lifetime (37% vs. 21%, respectively) (20). The study also reported that women with a disability were more than twice as likely to report a history of unwanted sex by an intimate partner (20% vs. 8%) (20). Adults with developmental disabilities are at risk of being physically or sexually assaulted at rates four to ten times greater than other adults (21). Deaf females have twice the risk of childhood sexual abuse compared to hearing children, and deaf males have five times the risk. In addition, a study of psychiatric inpatients found that 81% had been physically or sexually assaulted (22). There is some evidence that one subpopulation of people with disabilities may be at increased risk for perpetration; one study of a state prison population found that among incarcerated offenders, 32% of deaf inmates compared to 12% of hearing inmates had ever committed sexual assault (23).

# **The Magnitude of Sexual Violence in Massachusetts**

## **SEXUAL VIOLENCE PERPETRATION**

Data from multiple sources confirm that adults, adolescents and children perpetrate sexual violence. Most perpetrators are male, although people of other genders also sexually abuse. Often people who perpetrate sexual violence know their victims. Individuals who sexually abuse are probably as demographically diverse as any other subpopulation, but it is difficult to confirm this based on available data; we were unable to find any population-based data about sexual violence perpetration or perpetrators of sexual violence.

Most of the information about people who perpetrate sexual violence comes from studies of reported cases. While these studies are illuminating, they may also limit our understanding of this population in some ways. For example, most studies fail to differentiate individuals who have engaged in statutory rape, incest, exhibitionism, downloading child pornography, or homicidal rape. When perpetration data does differentiate between types of sexual violence, it is not always sensitive to “cross-over” between categories. Additionally, most cases of child sexual abuse reported to the police involve an adult male perpetrator in his 40s or 50s, so studies based on criminal justice data alone may reflect that. However, other studies have found that between 30 and 50% of child sexual abuse is perpetrated by another child or teen (24).

Data from samples limited to reported cases and/or from abusers who are in treatment are not likely to be representative of all people who have sexually abused, and therefore do not lend insight into all abusers’ behaviors, motivations, and ongoing risk to others. National studies suggest that between 12% and 36% of sexual assault victims report the assault to the police (25, 26, and 27), and that only about 6% of reported rapists will be incarcerated (RAINN, DOJ data). These data suggest that the majority of sexual abusers are not going to be known in their communities as people who have sexually abused others.

Understanding the limitations of data on perpetration is important in order to more accurately interpret the Massachusetts-based data we have available. According to criminal justice data, in 2007, there were approximately 8,900 registered sex offenders in Massachusetts, of whom 98.8% were male. These offenders age ranged from 9 to 86 years old; the median age was 30 years old. There are registered sex offenders in nearly all of Massachusetts’ cities and towns; there are more registered sex offenders per capita in the Central and Western regions of the state than in the Eastern regions, however. This does not necessarily mean there are fewer numbers of sex offenders (registered or undetected) in other parts of the state. In addition, from these data we know: (28)

- About two-thirds of rapes/sexual assaults occurred during the 12 hours from 6 p.m. to 6 a.m.
- Nearly 6 out of 10 rape/sexual assault incidents were reported by victims to have occurred in their own home or at the home of a friend, relative, or neighbor.

- Three out of four rape/sexual assault victimizations involved offenders (both single- and multiple-offender incidents) with whom the victim had a prior relationship as a family member, intimate partner, or acquaintance.

(Source: Astion M, Penman S, Fallon R. Understanding Sexual Victimization. Boston, MA: Executive Office of Public Safety, 2008.)

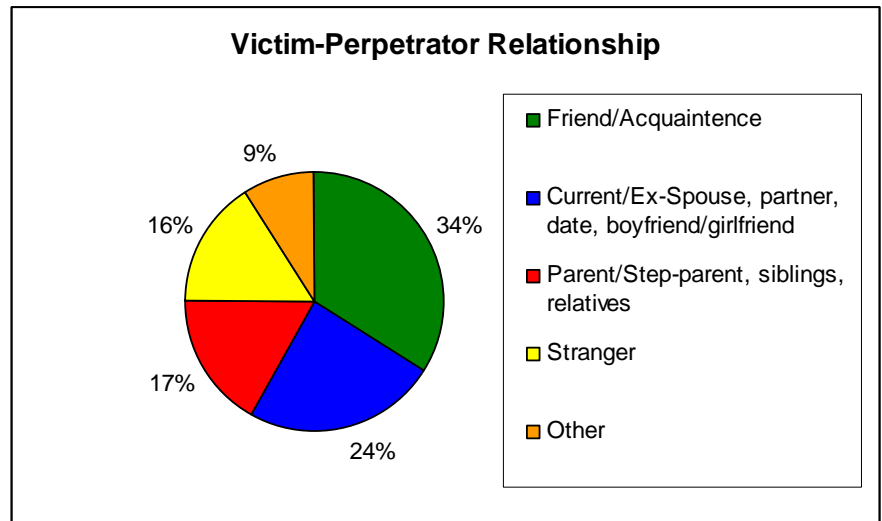
## Gender

Eighty-one percent of Massachusetts sexual assault reports to rape crisis centers in 2007 included information about the perpetrator. Of these cases, men were reported to have committed 95% of the assaults. Where both perpetrator and victim gender were known (77% of cases), 90% of assaults involved males perpetrating against females.

## Relationship

**Figure 1: Rape Crisis Center Data, 2005-06**

Victims of sexual violence do not always provide information on the individual who perpetrated the act. In 2005 and 2006, 81% of assault reports to RCCs provided information on victim-perpetrator relationship according to MDPH RCC data, 2005-2006 (see Figure 1). Survivors reported that friends and acquaintances committed 34% of assaults, followed by 24% current or ex-spouses or partners, dates, boyfriends/girlfriends; 17% parents, step-parents, siblings, or other relatives; 16% strangers; and 9% other perpetrators.



Data indicate that the relationship between perpetrators and victims varied based on the age of victims at the time of the assault. The youngest survivors (<13 years) were most often victimized by parents (37%) or siblings and other relatives (29%). Over 90% of perpetrators were known to these survivors. Adolescent survivors (13-19 years) most often reported the perpetrator as a friend or acquaintance (47%), followed by strangers (15%), and date/boyfriend/girlfriend (14%). Adult survivors (age 20 and over) most commonly identified perpetrators as friends or acquaintances (35%) and current and former partners (33%).

## **SEXUAL VIOLENCE VICTIMIZATION**

According to self-reported data collected through the Massachusetts Behavioral Risk Factor Surveillance survey (MA-BRFSS) in 2005, nearly 13% of adults ages 18-65 years old in Massachusetts have experienced unwanted sexual contact at some time in their lives (12).

### **Gender**

Massachusetts women are at increased risk for sexual violence victimization as compared to men; 17% of women and 6% of men report ever experiencing sexual violence (12). These estimates are consistent with the proportion of U.S. residents who report experiencing attempted or completed rape at some point in their lifetimes (17% of women and 5% of men (12).

High-school attending youth in Massachusetts also report experiencing sexual violence. Fourteen percent of girls and 6% of boys participating in the 2005 MA Youth Risk Behavior Survey (YRBS) report ever experiencing unwanted sexual contact, compared to 11% of girls and 8% of boys on the national YRBS report. No estimates of the prevalence of sexual violence victimization among transgender people from MA population-based surveys are currently available.

### **Race**

Among women who reported lifetime sexual violence (SV) victimization on the 2005 MA-BRFSS, there is substantial variation by race. Thirty-one percent of Black women reported sexual assault victimization, compared to 16% percent of White women and 12% of Hispanic women. However, the 2006 MA-BRFSS rates show rates of 12.7% for Black women and 14.5% White women.

Hispanic/Latina women in Massachusetts report SV victimization at approximately the same rate as White women according to MA-BRFSS data. However, Hispanic/Latina women may under-report SV as compared to White women, which would result in under-estimates of the magnitude of sexual victimization for Hispanic/Latina women.

Research suggests that many Mexican-American women may adhere to traditional gender roles, including sexual scripts that value women's submission to their husband's sexual advances (29). Moreover, married Latinas appear to be less likely to define forced sex as rape and to terminate their relationship when it occurs, because many view sex as a marital obligation (30). Accordingly, Mexican-American women are less likely than White women to use legal, medical, and judicial support systems following rape (29). Finally, accurate reporting on the incidence of sexual violence among Hispanic/Latina women could be affected by methodological problems that may disproportionately affect Hispanic/Latina people, including the use of survey instruments designed for White participants, use of English-only instruments, and use of sampling methods that discriminate against the inclusion of low-income, migrant, or mobile participants (31, 32).

## Income

According to MA-BRFSS data, there appears to be relatively little variation in sexual violence victimization by reported level of income, although those who earn the least (\$0-\$25,000 per year) are most likely to report lifetime experience of sexual violence; 14% of those in this income bracket report SV victimization as compared to 9-13% in the higher income categories.

## Sexual orientation

According to MA-BRFSS data, there are marked differences in the reported lifetime history of unwanted sexual contact by sexual orientation. A recent DPH analysis of 2001-2006 BRFSS data indicates GLB disparities: 13% of straight/heterosexual, 26% of gay/lesbian/homosexual, and 37% of bisexual adults reported ever being sexually assaulted<sup>†</sup>.

## Sexual Violence in GLBT communities

Research regarding sexual violence in GLBT communities is still relatively sparse. Most studies are cross-sectional in design and utilize community-based convenience samples, which limits generalizability. Studies of GLBT youth have found a prevalence of self-reported SV victimization from 14% to 33% (33-36). Bisexual youth may be at particular risk. One study found that youth who report having partners of both sexes are almost twice as likely to report sexual coercion and abuse as youth reporting only same sex partners (37). Population-based studies with subsamples of GLBT adults find a prevalence of lifetime SV that ranges from 12% to 48%, depending on the type of abuse and population examined (38). One study found that 63% of GLB adults reported experiencing some form of sexual victimization (39). Consistently, bisexual men and women are found to be more likely to report sexual violence victimization than gay, lesbian, or heterosexual individuals. For example, one population based study found that 32% of gay men, 44% of bisexual men, and 12% of heterosexual men reported experiencing childhood sexual abuse (40). The same study found that 44% of lesbian women, 48% of bisexual women, and 30% of heterosexual women reported experiencing childhood sexual abuse (40). In terms of adult and lifetime abuse, the patterns are consistent. When asked about sexual coercion in one study, 45% and 53% of bisexual men and women, respectively, reported they had experienced such an event, while 28% of gay men and 40% of lesbians reported the same (40).

Across studies of the perpetrators of SV against GLBT people, 75-100% were reported to be male. However, 24-41% of lesbian women reported being victimized by female perpetrators (40). One paper argues that a female perpetrator's denial is often supported by the heterosexual bias in the criminal justice and medical systems related to sexual violence (41). Other studies suggest survivors of same sex violence do not utilize agency support because of the perception that existing services are designed for female victims of male perpetrators

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<sup>†</sup> See document *A Health Profile of Massachusetts Adults by Sexual Orientation Identity: Results from the 2001-2006 Behavioral Risk Factor Surveillance System Surveys* at [http://www.mass.gov/Eeohhs2/docs/dph/health\\_equity/sexual\\_orientation\\_disparities\\_report.pdf](http://www.mass.gov/Eeohhs2/docs/dph/health_equity/sexual_orientation_disparities_report.pdf)

(42). The GLBT community is not uniform in its experience with sexual violence and plans to prevent SV must take differences into account.

### Disability Status<sup>#</sup>

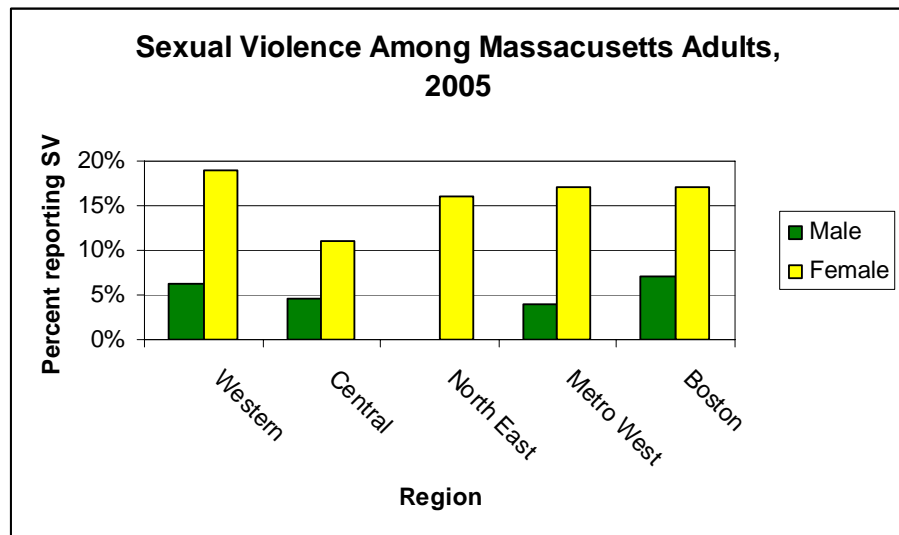
In 1999 and 2000, women 18-59 years old were asked if they had ever experienced unwanted sexual contact on the MA-BRFSS. Women with disabilities were much more likely to ever have experienced sexual assault, (i.e., unwanted sexual contact) compared to women without disabilities (34% vs. 18%, respectively). This was true for both younger and older women. However, the severity of disability did not appear to be related to the prevalence of sexual assault. In addition, in response to a question on the 2006 MA-BRFSS 22% of men with disabilities reported sexual abuse in their lifetime as compared to 6% of men without a disability.

Each fiscal year in Massachusetts, from 2005-2007, approximately 600-650 allegations of sexual assault of disabled persons have been reported to the Disabled Persons Protection Commission (see Appendix D). In 2005, 8% of these allegations were substantiated. In 2006, 6% were substantiated, and 5% of allegations made in 2007 have been substantiated. In FY08, 272 reports of indecent assault and battery and rapes were received by DPPC; the highest number of these reports received involved the abuse of people with developmental disabilities specifically.

### Residence

**Table 13**

Table 13 demonstrates the proportion of women and men who have reported experiencing sexual violence in their lifetime according to the MA-BRFSS. Although the proportions are comparable, the regions experiencing the most sexual violence appear to be the Western part of the state, and the Boston area.



### Sexual violence Victimization Magnitude Data (population-based)

National  
Violence  
Against  
Women  
Survey, 2000

MA BRFSS 2005 (including  
contact and non-contact  
sexual violence)

MA YRBS  
2005/2003\*

<sup>#</sup> BRFSS explanation of disability status: Adults who are limited in any activities because of physical, mental, or emotional problems.



	%		%		%
<u>Total</u>		<b>13% (2003)</b>			
<u>Sex</u>		Total			
Female	18%	17%			15%
Male	3%	6%			5%
F to M	-	-			-
M to F	-	-			-
Transgender	-	-			-
<u>Race</u>		Total	Female	Male	
White	18%	12%	16%	6%	10%
Black-American	19%	18%	31%	-	11%
Hispanic	15%	11%	12%	-	12%
Mixed race	24%	-	-	-	-
Indian/Native					
Alaskan	34%	-	-	-	-
Asian/Pacific					
Islander	7%	-	-	-	9%
Other	-	-	-	-	17%
<u>Current annual household income</u>		Total	Female	Male	
\$0-24.9K	-	14%	18%	6%	-
\$25-34,000	-	9%	12%	-	-
\$35-49,999	-	13%	18%	3%	-
\$50,000-74,999	-	12%	18%	5%	-
\$75,000+	-	13%	18%	-	-
<u>Sexual orientation</u>					
Gay, lesbian, or bisexual	-	36%			34%
Heterosexual	-	13%			9%
<u>Region of State</u>		Total	Female	Male	
Western	-	14%	19%	6%	-
Central	-	10%	11%	5%	-
Northeast	-	12%	16%	n/a	-
Metro West	-	12%	17%	4%	-
Southeast	-	15%	15%	n/a	-
Boston	-	14%	17%	7%	-
Students:					10%
with physical disabilities	-				18%*
without physical disabilities	-				9%*

**Limitations of data sources in above chart:**

NVAWS: The estimates from this survey, as from any sample survey, are subject to random sampling error. (Source: NVAWS, 2000) Data is only collected by landline phone numbers, and may not be representative of households without telephones, households in which other languages are spoken, incarcerated and homeless populations and institutionalized

populations. Data collected by the NVAWS are based on self-reported information from respondents. "Self-reported data may be subject to error for several reasons: an individual may have difficulty remembering events that occurred a long time ago or the frequency of certain behaviors; some respondents may over-report socially desirable behaviors or under-report behaviors they perceive to be less acceptable; and respondents may also report certain risks, behaviors and perceptions differently due to their respective cultural and linguistic backgrounds." (Source: MDPH, 2006)

BRFSS: Data is only collected by landline phone numbers in English, Spanish and Portuguese, and may not be representative of households without telephones, households in which other languages are spoken, incarcerated and homeless populations and institutionalized populations. Survey has same limitation regarding self-reporting as NVAWS. (Source: MDPH, 2006)

YRBS: There are only two questions pertaining to sexual assault; does not capture private school students and dropouts; sample sizes limits ability for detailed analysis. Survey has same limitation regarding self-reporting as NVAWS. (GCSDV, 2005)

\*where indicated data is from the YRBS, 2003.

## **Risk and Protective Factors for SV**

### **Risk Factors**

In order to prevent sexual violence (SV) by addressing risk factors for its occurrence, we must first explore the concept of risk. For the purposes of our planning, we consider a condition or experience to be a “risk factor”<sup>3</sup> for sexual violence if exposure to that factor, as compared to no exposure, is associated with the occurrence of SV. *Thus, determining if something is a risk factor does not depend on whether the majority of people exposed to the factor experience sexual violence or not, only whether more people who are exposed than unexposed do.*

A second important point about risk is that it is not useful for making predictions about individuals. Not all factors that are associated with sexual assault victimization or perpetration contribute causally to them. Sometimes factors are associated with—but not causally related to—sexual assault. One cannot assume that the so-called “risk factor” leads to sexual assault.

The scientific literature indicates that there is no single cause of SV. This means one cannot say that if a certain societal condition or individual characteristic is eliminated, then a person will never perpetrate SV.

### **Issues to consider regarding risk and protective factors for SV**

The research about risk and protective factors for sexual violence victimization and perpetration is limited. For this report, a comprehensive list of factors has been compiled from various published, scientific sources. However, the literature does not distinguish between risk and protective factors for individuals by demographic characteristics (e.g., by age of the perpetrator or victim) or for various typologies (e.g., rapist versus sexually reactive youth). Collecting and examining new data on risk and protective factors in sub-populations in the state with special emphasis on diversity related to age, gender, race, ethnicity, sexual orientation, socioeconomic status, disability status, acculturation status and/or geographic location would be beneficial and important, but is beyond the resources of the SPT in our planning phase.

The following list of factors should be used as a guide for primary prevention work and not be seen as prescriptive. Sexual violence is a complex problem, therefore requiring complex solutions.

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<sup>3</sup> Note that the term “risk marker” is the term more frequently, and perhaps appropriately, used in epidemiologic literature.

## Protective Factors

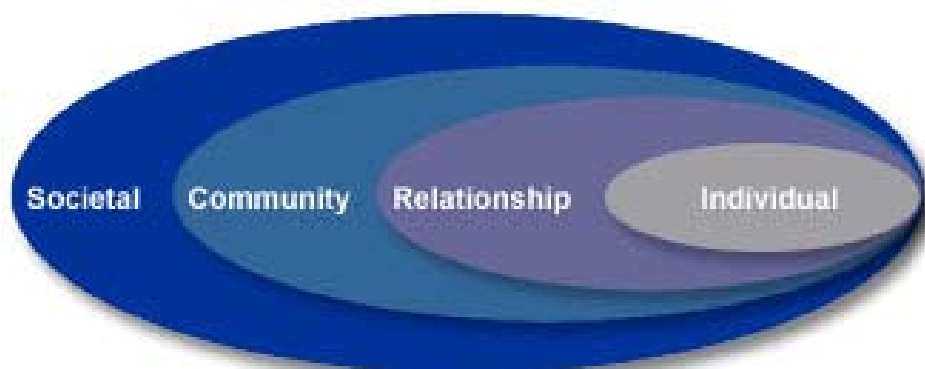
While protective factors may decrease the risk of perpetration or victimization, they are not immunizing. In addition, while research about the efficacy of protective factors in preventing sexual violence is limited, it can be helpful to understand what is known about resiliency and assets.

The scientific literature indicates that there is no single way to prevent SV. This means one cannot say that if a certain societal condition or individual characteristic is eliminated, then a person will never be a victim of SV.

[Note: Additional factors that may impact perpetration or prevention of sexual violence in MA are referenced in the introduction to this report]

## RISK AND PROTECTIVE FACTORS IDENTIFIED BY THE MASSACHUSETTS STATE PREVENTION TEAM

The social ecological model is a nested model where the individual level is nested within relationships, the community, and the larger society. These four levels are connected and reinforce each other, while



The social ecological model is a nested model where the individual level is nested within relationships, the community, and the larger society. These four levels are connected and reinforce each other, while representing separate, but complementary avenues through which sexual violence may occur and through which sexual violence can be prevented. Sexual violence is therefore thought to be the result of a complex interplay of factors from each level of the social ecological model. In combination, risk factors may increase the likelihood or risk of perpetration.

Individual risk factors for perpetration include knowledge, attitudes, beliefs, behavior (often referred to as KABB) supportive of sexual violence perpetration, personal experiences such as childhood history of abuse or witnessing family violence, adherence to traditional gender roles, and alcohol and drug use (15). Certain relationship conditions can also increase risk of perpetration. Examples of relationship level risk factors include association with sexually aggressive peers, or marital conflict (15, 43). Community level risk factors are situated within the context of people's lives such as work, school, and social environments. Examples of risk factors at the community level include high rates of unemployment, weak community and system sanctions, and lack of or no enforcement of policies against sexual harassment (15, 43). Finally, societal risk factors are those conditions that effect many individuals and

communities such as a sense of male entitlement over women, masculinity defined by dominance, and cultural values supportive of violence as a way to resolve conflict (15, 43).

note: We will be focusing on Community and Societal Factors but are listing Individual and Relationship Factors for guidance purposes and to ensure attention to every level of the social-ecological framework. The following information has been gathered from multiple sources including:

- The National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
- MA Executive Office of Public Safety, Batterers Intervention Curriculum
- World Report on Violence and Health, World Health Organization
- Search Institute

Individual and Relationship Risk Factors for SV	
Perpetration	Victimization
Alcohol and drug use	Prior history of sexual violence
Coercive sexual fantasies	Gender
Impulsive and antisocial tendencies	Young age
Preference for impersonal sex	Drug or alcohol use
Hyper-masculinity	High-risk sexual behavior
Childhood history of sexual and physical abuse	Poverty
Witnessed family violence as a child	Ethnicity/culture
Association with sexually aggressive and delinquent peers	Witnessing physical or psychological intimate partner abuse (intimate partner violence)
Family environment characterized by physical violence and few resources	
Strong patriarchal relationship or familial environment	
Emotionally unsupportive familial environment	
Young age (intimate partner violence)	
Perceived sexual rights in intimate relationships	
Poor family functioning (e.g. poor attachment, harsh discipline)	
Family honor considered more important than the health and safety of the victim	

Community and Societal Risk Factors for SV	
Perpetration	Victimization
Lack of employment opportunities	Unemployment rate
Absence of deterrence (i.e. no consequence) for engaging in bullying or sexual violence perpetration	Societal norms that maintain women's inferiority and sexual submissiveness
Poverty, mediated through forms of crisis of male identity	
General tolerance of sexual assault	
Weak community sanctions against perpetrators	
Societal norms supportive of sexual violence and male sexual entitlement	
Weak laws and policies related to gender equity	
High levels of crime and other forms of violence	
Rigid gender roles	
Traditional gender norms	
Definitions of masculinity that are linked to dominance	
Lack of institutional support	
Cultural values supportive of violence as a way to resolve conflict	

Protective Factors for SV	
Perpetration	Victimization
Connectedness/relationship with school and/or community	Availability of services
Caring school climate	Support and belonging
Availability of services	
Support and belonging	
Status of women	
Collective efficacy – the degree to which a community is able to effectively mobilize to regulate local crime	
Positive youth development	

## Assets and Resources in Massachusetts for SV Primary Prevention

*Note: Community level risk and protective factors are those that can be located in places where people live and work, including schools, neighborhoods, workplaces, and social settings. The following section utilizes this concept of “community.”*

The assets assessment workgroup of the SPT conducted three separate surveys in January 2007 in order to assess the strengths and resources of Massachusetts for sexual violence primary prevention efforts. The following surveys were implemented:

- a survey of 150 service and prevention program providers from any field to identify existing assets in and known by these programs
- a survey of 16 Rape Prevention and Education (RPE) programs currently federally funded through the MA Department of Public Health (DPH) to identify existing assets for SV prevention in and known by these programs (see appendix).
- a community-focused survey of 93 members of the public about personal resources and potential assets for addressing sexual violence

While respondents to these surveys were a “convenience sample” (rather than a random sample), which limits generalizability of findings, our results are nevertheless useful for planning purposes.

State level Assets
<ul style="list-style-type: none"> <li>• Massachusetts has a Governor/administration supportive of prevention</li> </ul>
<ul style="list-style-type: none"> <li>• Massachusetts has a diverse citizenry (age, sexuality, ethnicity), and high concentration of colleges/universities</li> </ul>
<ul style="list-style-type: none"> <li>• Massachusetts’ wealth of activist organizations was likewise considered an important strength. Massachusetts has many established <i>statewide</i> coalitions and organizations already committed to and supportive of prevention activities, and many that are explicitly working on issues of violence (e.g. child sexual abuse and exploitation, sexual and domestic violence, youth violence). Please see Appendix D for a list of organizations. Existing coalitions emphasize aspects such as networking and mutual support, advocacy and organizing, capacity-building and training, advisory and planning functions, and multidisciplinary service coordination</li> </ul>
<ul style="list-style-type: none"> <li>• Current funding resources that are currently being utilized to support sexual violence prevention work in Massachusetts at various levels include: DPH, Department of Social Services, Title X, VOCA (Victims Of Crime Act), NIJ (National Institute of Justice), VAWA (Violence Against Women Act), National Crime Prevention, private funds, and general operating funds</li> </ul>
<ul style="list-style-type: none"> <li>• The state Department of Public Health demonstrates organizational commitment to and capacity for the development of sexual violence prevention initiatives including full-time staff dedicated to sexual violence prevention. It also has developed and implemented contractual pre-service training standards for all RPE grantee prevention educators, to support the principle of well-trained staff</li> </ul>

- Several national violence prevention organizations physically located in Massachusetts were also noted as statewide resources to consider, such as the Family Violence Prevention Fund, Stop It Now!, and Mentors in Violence Prevention (MVP)

### Community/organizational level assets

- Many local cities, towns and counties have existing multidisciplinary coalitions (a.k.a. task forces, roundtables, etc.) on violence and related services. These multidisciplinary groups are brought together by different conveners in different communities, such as police, district attorneys, health and human services, mayor's office, etc. See Appendix E for a list of coalitions
- Some local coalitions were organized around more specific populations or service sectors (e.g., Boston Area Campus Sexual Assault Coalition, Suffolk Co. Teen Prostitution Collaborative, Coalition of Boston Teaching Hospitals, and Archdiocese of Boston Child Abuse Prevention Teams)
- Many local programs and organizations in Massachusetts are already committed to, supportive of, and engaged in prevention activities. These include rape crisis centers, domestic violence and batterer intervention programs, sexual abuser programs, child advocacy centers, hospital-based programs, and public health programs (family planning, community health centers). See Appendix E
- Additional types of organizational structures within communities should also be considered and engaged in sexual violence prevention work. These include faith-based and civic groups, youth networks, schools, local media and political leaders, and social and health organizations including CHNAs (Community Health Network Areas). See Appendix E. Financial support (for staff and travel), explicit information and invitations, and assurance of cultural competence and strategic value would support the involvement of additional interested stakeholders in coalitions to prevent sexual violence

Support is needed to increase agency leadership capacity for and commitment to evaluation of sexual violence prevention and to full knowledge and integration of this work.

### Individual level assets

- The area where most respondents are doing sexual violence prevention work is in their personal lives by talking about sexual violence with their colleagues, children, friends, and young people in their lives, and through volunteer work, training events, religious communities, book groups, self-defense classes, and neighborhood groups.
- Individuals are promoting healthy relationships and sexual non-violence at work, by talking to partners, setting a positive example, and participating in community events.
- Informal resources such as, health care providers and friends are the most frequent supports for community members to engage in this work. Formal



resources such as rape crisis centers, Jane Doe, The Network/La Red etc. were also named if they were trusted.

As part of their current DPH-contracted prevention activities, all MA RPE-funded programs have chosen at least one focus community to work intensively with on sexual violence prevention. In 2006, RPE Programs were asked to choose a focus community with which they had a strong existing relationship with or otherwise demonstrated a high capacity or readiness to begin sexual violence prevention work. The following focus communities were chosen. Please note that all communities are within specific service areas, not statewide, and that some programs chose more than one focus community or their chosen community overlapped across groupings (e.g., Latino youth fall under both “Youth” and “Linguistic-specific Communities”).

Local RPE Focus Communities	# RPE Programs that Selected
Youth (elementary/middle/high school)	10 (5/7/9)
Colleges/College Students	4
Child, youth, and family service providers	1
Native American community	1
Males	1
Linguistic-specific communities	4
Head Start programs	1
People with Disabilities	1
Faith Community	1

The programs are required to meet specific sexual violence prevention criteria, based on standards in the Community-Based Sexual Assault Prevention and Survivor Services RFR; the criteria are as follows:

The goal of prevention services is to change social norms within communities to reduce the perpetration of sexual assault across the lifespan through:

- Promotion of healthy, respectful, developmentally-appropriate relationships and sexuality based on the human rights of sexual autonomy and bodily integrity
- Promotion of community-wide responsibility for consistently supportive responses to survivors and for holding abusers accountable
- Sexual assault prevention community organizing and leadership utilizing culturally-appropriate strategies of community development, education, mobilization, and professional training.

However, much silence remains about sexual violence. In order to be more effective at participating in sexual violence prevention, community members need more training, skills, and materials on *how* to talk about sexual violence and how to be an activist, as well as support from the media, men, peers, partners, schools, providers, and family for this work. More services such as a statewide hotline for SV and internet access to resources and materials may be helpful, as well as greater understanding of “-isms” and integration of SV prevention with other issues.

Individuals also feel its important to incorporate more community sectors, leaders, and safe spaces in sexual violence prevention, including men, survivors, artists, immigrants, people of color, GLBT folks, various professions (police, medical, sex offender treatment), youth, local media and government, liquor/bar associations, labor unions, churches, sports teams, and other groups.

## Massachusetts' Systems Capacity to Support Primary Prevention of SV

There are many ways in which the organizations and agencies in Massachusetts can be improved to support and sustain the primary prevention of SV. An effective primary prevention strategy for SV must include a variety of entities from around the state.

The following tables\* explain types of systems capacity and the condition of them in Massachusetts currently, with responses based on a self-assessment by SPT members in 2008.

System Profile	
<b>Scope and Breadth of System</b>	<b>Moderate</b>
A statewide prevention team is beginning to take shape. The SPT is helping to bring together aspects of the system. Integration of healthy sexuality/relationships is progressing across the DPH and its vendors. Although in its formative stage, the Be SAFE initiative (out-of-school program to educate at-risk youth and their providers about sexual health, violence and substance use) is an example of this process.	
<b>Regulatory, legal or statutory environment</b>	<b>Moderate</b>
A comprehensive health education bill is widely endorsed but has not yet passed, and there is a comprehensive sex offender management board proposal under development. By executive order the Governor has established the Governor's Council to Address Sexual and Domestic Violence.	
<b>Administrative structures and reporting relationships</b>	<b>Moderate</b>
The newly formed Governor's Council supports prevention.	
<b>Funding streams for SV primary prevention</b>	<b>Moderate</b>
There are few non-federal sources of funding, though state funding of sexual and domestic violence prevention was in the state budget for the first time this year. Programs use foundation funds where available.	
<b>Key Stakeholders, Partners, and relationships</b>	<b>Moderate</b>
Relationships and partnerships are emerging that connect SV prevention with the	

\* This format was provided by the CDC's vendor, Mathematica Policy Research, Inc.

<p>following groups: MA Child Sexual Abuse Prevention Partnership (MCSAPP); the MA Coalition for Sex Offender Management (MCSOM); the SPT; the MA Coalition for Youth Violence Prevention; Coalition Advocating Responsible Education (CARE) for Youth; the Governor's Council to Address Sexual and Domestic Violence; Be SAFE; Healthy Fatherhood work across state agencies with JDI; Trafficking Victims Outreach and Services Network (TVOS), and the Support to End Exploitation Now (SEEN) Network. A wider integration with marginalize groups and community organizers is needed.</p>	
The alignment of missions, visions, values among stakeholders or partners	Moderate
The relationships listed above are facilitating values sharing.	
<b>The commitment to primary prevention, planning, and evaluation across the system</b>	<b>Moderate</b>
There is a strong foundation for this through the RPE program, TA and outreach. Work is beginning on broader investment in SV primary prevention and knowledge/resources to support greater evidence base and commitment to evaluation.	

<b>Leadership</b>	
<b>The recognition and established legitimacy of leadership</b>	<b>Moderate</b>
SV prevention leaders are sought for involvement in major new state initiatives like the Governor's Council, and the priorities of the DPH Commissioner. These initiatives are new and it is not clear how SV prevention will be implemented.	
<b>Leadership style</b>	<b>Moderate</b>
<b>Cultural sensitivity of leadership values</b>	<b>Moderate</b>
Have identified occurrences through SPT process, Hartford RPE institute debriefing that included non-traditional SV partners.	
<b>Shared leadership values and vision</b>	<b>Moderate</b>
Shared values and vision are emerging, in part, as a result of the SPT process.	
<b>Leadership commitment to public health approach to primary prevention</b>	<b>Moderate</b>
<b>Leadership Development</b>	<b>Moderate</b>
JDI continues efforts with membership, capacity building with "front-line" staff. More leadership development is needed.	
<b>Scope of leadership development</b>	<b>Moderate</b>
Some expansion of scope through both the Refugee and Immigrant Support and Empowerment Program (RISE) and the SPT.	
<b>Intergenerational aspects of leadership development</b>	<b>Low</b>
The Youth Violence Prevention Coalition has a youth advisory board, there are some peer education and youth development initiatives in development with Be SAFE, CARE is establishing a student-parent advisory council, there is some	

college campus organizing of volunteers and internships. Despite this, there are few opportunities for real youth leadership within SV prevention programs.

Strategic Planning	
<b>Motivation for SV primary prevention planning</b>	<b>Moderate</b>
SPT using GTO. Governor, Secretary of HHS, and DPH Commissioner prioritizing evidence based prevention; reinforces efforts such as CARE for Youth and other healthy sexuality/violence prevention efforts. There are many opportunities here, but they are all in preliminary stages.	
<b>Approach to developing statewide SV prevention strategic objectives</b>	<b>Moderate</b>
SPT is using GTO. Local RPE grantees are all developing capacity around primary prevention.	
<b>Strategic focus on primary prevention</b>	<b>Moderate</b>
SPT is using GTO. Local RPE grantees are all developing capacity around primary prevention.	
<b>Use of evidence for SV prevention planning</b>	<b>Moderate</b>
SPT is using GTO and available data sources to set the course for primary prevention. Data sources, however, are limited for certain populations.	
<b>Community input into the strategic planning process</b>	<b>Moderate</b>
Broad community surveying efforts were put forth for the SPT step 1 report. State guidance for local RPE assessments is designed to incorporate community input. Work needs to continue to include all communities in the process.	
<b>Diversity of constituencies involved in planning</b>	<b>Moderate</b>
SPT membership was adjusted specifically for this purpose.	
<b>Accountability of statewide SV prevention planning to communities and constituencies</b>	<b>Moderate</b>
The results of the community survey were disseminated back to the community as part of the GTO/SPT process. Additional community and constituency accountability is being considered and is needed.	
<b>Implementation of statewide SV prevention strategic objectives and action plans</b>	<b>Moderate</b>
The preliminary RPE plan is in full implementation, however, the implementation of local action plans vary. A broader statewide SV action plan is still under development by SPT.	
<b>Measurement and evaluation of progress</b>	<b>Moderate</b>
The statewide plan to be developed by SPT will be broader and more extensive. RPE program and local grantees currently have preliminary goals/objectives and need to submit progress reports.	

Information	
<b>Approach to gathering, analyzing, and managing data for knowledge-driven performance in SV primary prevention</b>	<b>Moderate</b>

SPT is using GTO. Data sources such as the BRFSS, YRBS, and RPE grantee data systems are being used in program planning. SPT has identified that more data on protective factors, marginalized populations, and perpetration intent and behavior are needed.	
<b>Use of information technology (IT) in gathering, analyzing, and managing data</b>	<b>Moderate</b>
Many systems especially about victimization and criminal justice have been developed in MA, but they are not well integrated. Little primary prevention specific data is gathered electronically, or at all.	
<b>Efforts to use data to assess and inform performance</b>	<b>Moderate</b>
The GTO process is clearly focused on this and some use of data locally occurs with RPE support.	
<b>Data quality and utility</b>	<b>Moderate</b>
There are extensive cross-agency efforts in this area. However, staff turnover, pay scales for technical positions, and crisis service and response needs at state and non-profit agencies challenge consistent quality.	

<b>Community and Constituency Focus</b>	
<b>Relationships with SV prevention constituencies and communities across the state</b>	<b>Moderate</b>
Many relationships throughout the state have already been highlighted (Be SAFE, cross-DPH efforts). Cultivation of relationships is specifically needed in sectors such as community development, and faith based groups.	
<b>Outreach to diverse constituencies</b>	<b>Moderate</b>
Programs like RISE, Faith, and GLBT state-supported initiatives are a start. Outreach is still under development.	
<b>Outreach to communities who have not participated in the past</b>	<b>Moderate</b>
Outreach is still under development, but has been initiated with groups such as the Men's Initiative for JDI, and Healthy Fatherhood programs.	
<b>Processes and mechanisms for gaining knowledge about communities and constituencies</b>	<b>Moderate</b>
GTO process including Step 1 surveys, SPT. The Governor's Council is developing a process. More far-reaching efforts are needed in this area.	
<b>Mechanisms for ensuring accountability</b>	<b>Moderate</b>
Some mechanisms are in place such as RPE grantee community assessment. Additional methods are being considered. Surveying has also been part of the GTO/SPT process.	
<b>Community involvement and ownership in primary SV prevention planning, implementation, and evaluation across the state</b>	<b>Low to Moderate</b>
Some programs are utilizing community assessments, advisory groups, community organizing approaches, and/or inclusion of community-level leaders	

in planning. There appears to be a growing consensus of the value of community involvement.

Human Resources	
<b>Organization of work systems, work teams, and/or work units for SV prevention</b>	<b>Moderate</b>
These are emerging as indicated by Step 1 surveys, but appear to be very uneven.	
<b>Processes and practices for recruitment, hiring, and promotion</b>	<b>Moderate</b>
Improvement is visible as evidenced by an increased in the number of men being recruited for prevention work, but more is needed.	
<b>Retention of SV prevention staff</b>	<b>Low to Moderate</b>
Difficult to measure. The perception is that turnover of SV prevention staff is fairly consistent with a core cadre of longer-term prevention staff. Staff hired to focus on primary prevention is a new concept in many places. It appears that turnover of executive level staff, who are needed to support SV prevention, is higher recently.	
<b>Job descriptions and performance management</b>	<b>Moderate</b>
These are in the early stages of emerging.	
<b>Training, development, and motivation of the workforce</b>	<b>Moderate to High</b>
There is a strong commitment to statewide primary prevention education and training through JDI and DPH systems, Be SAFE, MCSAPP, and others.	
<b>Work environment of the SV primary prevention workforce across the state</b>	<b>Moderate to High</b>
Educator /Training WG, SAAB, DPH bimonthly TA calls, SPT, etc.	
<b>Extent to which work environments support SV prevention planning, implementation, and evaluation</b>	<b>Moderate</b>
CDC SV prevention 101 training statewide and other emerging efforts.	

System Operations	
<b>Alignment of SV prevention programs and statewide strategic objectives</b>	<b>Moderate</b>
RPE grantees and partners are guided together toward current objectives. SPT strategic objectives will be identified for local alignment.	
<b>Collaboration across programs</b>	<b>Moderate</b>
Collaboration is occurring across several programs such as Be SAFE, DPH, MCSOM, and Youth violence. This process is ongoing.	
<b>Shared learning across programs</b>	<b>Moderate</b>
Many initiatives are beginning. Healthy sexuality/relationships concepts are being included in HIV prevention, safe communities for GLBT youth, youth violence prevention RFRs, school health initiatives and healthy fatherhood training initiatives. Community assessment and planning are being incorporated at RCC's	

and Llámanos. JDI is also performing community development framework trainings.	
<b>Public health approach</b>	<b>Moderate</b>
This issue is emergent as evidenced by local RPE objectives being submitted to DPH.	
<b>Operational planning, implementation, and evaluation</b>	<b>Moderate</b>
SPT is using GTO, local RPE grantees are all developing capacity for assessment based prevention objectives.	
<b>Sustainability</b>	<b>Low to Moderate</b>
Greater cultivation of resources to supplement RPE and expand approaches and capacity are needed. We are seeking to institutionalize the sustainability of prevention efforts through a health education bill and emerging funding opportunities.	

<b>Results/Outcomes</b>	
<b>Demonstrated Results/Outcomes in building system capacity</b>	<b>Low to Moderate</b>
The Step 1 report and this current assessment provide some positive results and trends regarding multidimensional system capacity performance. This current assessment will provide a baseline for future results and trend analysis.	
<b>Demonstrated outcomes in increasing protective factors or reducing risk factors for sexual violence</b>	<b>Low</b>
We are at a stage of identifying risk and protective factors with the assistance of the CDC. Results have not yet been measured. Outcomes will be part of the evaluation plan under SPT's plan.	
<b>Demonstrated outcomes in preventing sexual violence</b>	<b>Low</b>
Outcomes in this area will also be part of the evaluation plan under SPT's plan.	

## **SV primary prevention systems capacity**

Our assets assessment results identified an array of prevention system issues, for example:

- a) Community focus – Many respondents felt that additional types of organizational structures within communities should be considered and engaged in sexual violence prevention work.
- b) Human resources – Some programs surveyed indicated that the people at their agencies who deliver SV prevention strategies be trained in presentation skills, specific curricula, community organizing, social norms, and/or working with systems.
- c) Information – Broader provision of explicit information would support the involvement of more stakeholders in SV prevention work. Also, in order to be more effective at participating in sexual violence prevention, community members need more training, skills, and materials on *how* to talk about sexual violence and how to be an activist, as well as support from the media, men, peers, partners, schools, providers, and family for this work.
- d) Leadership – Massachusetts has many local programs and organizations already committed to, supportive of, and engaged in prevention activities, but additional support is needed to increase agency leadership capacity for and commitment to evaluation of sexual violence prevention and to full knowledge and integration of this work.
- e) Results documented - Most respondents engaged in SV prevention work did not indicate that they are documenting results and outcomes of their SV prevention efforts yet.
- f) Strategic planning - Existing statewide coalition functions named by respondents included planning activities; there is interest in building upon previous strategic planning efforts.
- g) System operations - Many partnerships for SV prevention work exist; additional financial support (for staff and travel) and explicit information and invitations would support the involvement of additional interested stakeholders in sexual violence prevention coalition work; more services such as a statewide hotline for SV and internet access to resources and materials may be helpful, as well as greater understanding of “-isms” and integration of SV prevention with other issues.



## Barriers to Primary Prevention of SV in Massachusetts

Barriers may also exist in relation to the goal of primary prevention of sexual violence, and it is important to discuss the barriers that may exist in Massachusetts. Barriers were determined using an online survey. Members of the Barriers Workgroup also solicited opinions from SPT members on barriers to primary prevention of sexual violence. The charts below address important potential barriers to the primary prevention of SV.

<b>Legislative and Political Barriers</b>
Discomfort publicly acting on behalf of historically “marginalized” populations (e.g., GLBT persons, immigrants, sex workers) can be politically uncomfortable.
Sometimes “prevention” work is viewed more narrowly as only “applying tougher laws.”
Understanding of and comfort promoting comprehensive sex education can be politically challenging.
Existing funding sources tend to focus only on needed direct services without additional funding for prevention.
Need to provide opportunities for lawmakers to receive data-informed information about the importance of sexual assault prevention. As one individual commented: <i>“Some ... sex offender related legislation (e.g., residency restrictions) is a barrier to owning up to the fact that we continue to “create” abusers as a society and own up to what we really need to do to prevent the development of what may be the most common types of perpetration ... in the first place.”</i>

<b>Legal and Judicial Barriers</b>
Existing laws and judicial interpretations are inadequate to protect victims of sexual assault (e.g., recent Supreme Court case that determined that “sex” by “fraud” was not criminal)
Existing laws are more or less sufficient, but judges and juries are too often unwilling to apply them justly and consistently
Both of the above situations likely contribute to a societal barrier where the perceived sanctions for crimes related to sexual violence are weak or nonexistent
There are unclear “rules of engagement” when interacting with adults who are suspected of perpetration due to confidentiality legislation, particularly in college settings
There is often difficulty in obtaining restraining orders for victims of sexual violence

<b>Community Barriers</b>
Lack of financial support for staff and travel in coalition work to prevent SV
Lack of explicit information and invitations for involvement of additional stakeholders in SV prevention coalitions
Lack of support to increase agency leadership capacity to evaluate SV prevention programs
Community members not trained on how to talk about SV and how to advocate for the prevention of SV

<b>Potential Barriers for Specific Populations</b>
Tendency of non-majority populations to be distrustful of “mainstream” organizations and institutions that might respond to incidents of SV
Few men in the SV prevention movement, especially young men
Certain faiths may promote messages contrary to effective sexual assault prevention work, such as promoting rigid gender roles founded on male supremacy
Language barriers for immigrant populations
Broad perception that individuals with disabilities are asexual
Tendency of some health care personnel to feel driven by reimbursement systems or think that they already “know it all”
Tension between serving all populations and providing tailored prevention services to specific groups
Difficulty obtaining access and time for SV prevention in school settings, especially colleges and universities

# System Capacity, Universal and Selected Population Need Statements

## **System Capacity**

**Need:** The Commonwealth of Massachusetts can improve the state prevention system capacity in a number of ways. We can build a wide range of providers' and system capacity to engage in the primary prevention of sexual assault, improve data collection and use, and foster new intra-agency linkages. For example, several goals to improve our state's prevention system capacity appear in this plan's universal and selected population goals. In addition to those population-specific system goals, the capacity of our Rape Prevention and Education (RPE) system itself needs to be expanded. Current and future personnel in the RPE system in Massachusetts can provide leadership as Massachusetts operationalizes the critical concepts of primary prevention and intersectionality of oppressions. It is also essential that the RPE system and its partners are able to effectively implement culturally-appropriate prevention strategies with the following selected populations indicated by the SPT's needs assessment: marginalized racial/ethnic populations, people who are GLBT, deaf and people with disabilities, and faith communities.

## **Universal Population**

### **Youth**

**Need:** Children, adolescents, and college students are at high risk for experiencing sexual assault (4, 44). As many as 20-33% of girls and 10-14% of boys are sexually abused before age 18 (44). It is estimated that between 30-50% of sexual abuse of children is perpetrated by other youth (24). Approximately 15-25% of U.S. college women have experienced SV, and Massachusetts is home to a proportionately large college population. Youth is a key period for development of relationship values, attitudes and behaviors. Therefore, there is a need to promote healthy, respectful relationship and sexuality norms—and behaviors—with children, adolescents, and young adults in Massachusetts.

## **Selected Populations**

### **GLBT Individuals**

**Need:** GLBT people are at increased risk for sexual violence victimization as compared to their heterosexual counterparts. A recent DPH analysis of 2001-2006 BRFSS data indicates GLB disparities: 13% of straight/heterosexual, 26% of gay/lesbian/homosexual, and 37% of bisexual adults reported ever being sexually assaulted. These populations face additional barriers to receiving necessary services and benefiting from prevention programming. In order to improve our state's ability to prevent the perpetration of sexual violence against GLBT people, we need to prepare MDPH-funded programs to engage in this work. Furthermore, we need to collect more and better quality data about the sexual violence victimization experiences of GLBT people in order to inform prevention programming.

### **People with Disabilities**

**Need:** According to the majority of published reports, individuals with disabilities are more likely than those in the general population to experience sexual assault victimization (20, 46-49). For adults with developmental disabilities, the reported rate of sexual assault is 4-10

times greater than other adults (4, 21, 44). In Massachusetts, there is a need to increase understanding of healthy sexuality and healthy sexual behaviors among youth and adults with developmental disabilities, and to improve the environments in which people with developmental disabilities live, work, and recreate so that they support these healthy behaviors.

#### **IV. Sexual Violence Primary Prevention Plan 2009-2016: Goals, Objectives, and Evidence-Based Strategies for Systems, Universal, and Selected Populations**

Key considerations for goals, objectives, and strategies across all populations (youth, GLBT individuals, people with disabilities, and system capacity):

**Comprehensive:** Building state prevention system capacity must be done in conjunction with capacity building at the local level. Prevention strategies will be “packaged” in a comprehensive way within a community, together with competent services related to risk-reduction (e.g., Child Abuse Prevention Program, Talking About Touching, self-defense/empowerment programs), victimization (e.g., trauma-sensitive schools initiatives, trauma-informed care trainings, rape crisis centers, Child Advocacy Centers, trauma-sensitive schools) and abusive behavior (e.g., specialized referral, assessment and treatment for children with sexual behavior problems, enforcement) response. Funding for Implementation may be prioritized to communities with readiness to approach prevention in a comprehensive manner, and to developing readiness with adults in a community to support youth-focused work.

**Intersectionality of oppressions:** “Intersectionality of oppressions” is defined as the ways in which various socially and culturally constructed categories interact on multiple levels to create inequalities in society. Intersectionality holds that oppressions within society, such as those based on race/ethnicity, gender, religion, nationality, sexual orientation, class, or disability do not act independently of one another; instead, these forms of oppression interrelate creating a system of oppression that reflects the “intersection” of multiple forms of discrimination. These concepts are especially important in the development and implementation of prevention initiatives as they directly connect to the theories of causality, contribute to a broader understanding of the implications of strategies, and impact outcomes in terms of ensuring that stereotypes and misconceptions are not promoted. Given that sexual and domestic violence have complex dynamics and impact populations in different ways, an understanding of the intersections of oppression is critical in developing approaches that are guided and informed by diverse people.

**Trauma-informed prevention:** Prevention strategies must be based in an understanding that any population selected for prevention activities will include people who have already experienced sexual abuse or who have abused others. Prevention programs will therefore commit to avoiding re-traumatizing, blaming victims, or colluding with abusive behavior/attitudes. They should also ensure that those delivering prevention activities have

sufficient knowledge, skills, and connection to specialized assessment and treatment services to be effective bridges to those services when disclosures do occur.

**Culturally-Relevant** Fit, Inclusion, Community Ownership, Community Knowledge, Social Justice: Because culture is central to prevention and evidence indicates that “one size fits all” approached tend to be less effective, strategies utilized to meet the goals in this plan must include culturally-specific approaches for populations that have borne a disproportionate burden of sexual violence and that been historically underserved. These strategies must be developed in collaboration with the specified populations.

**Sustainability/accountability:** We recommend an ongoing collaborative, multidisciplinary group to take responsibility for these goals and be accountable for them (e.g., ongoing SPT).

**Note:** Throughout the Goals section, an asterisk (\*) indicates that the objective is also a state system capacity objective. An (RPE) indicates recommendation for use of RPE funds.

## **A. Sexual Violence Prevention System Capacity**

### ***With specific focus on the RPE System***

**Need:** The Commonwealth of Massachusetts can improve the state prevention system capacity in a number of ways. We can build a wide range of providers’ and system capacity to engage in the primary prevention of sexual assault, improve data collection and use, and foster new intra-agency linkages. Several goals with strategies to improve different state system prevention capacity appear in this plan’s universal and selected population goals. In addition to those population-specific system change goals, the capacity of our Rape Prevention and Education (RPE) system itself needs to be expanded. Current and future personnel in the RPE system in Massachusetts can provide leadership as Massachusetts operationalizes the critical concepts of primary prevention and intersectionality of oppressions across multiple systems. It is also essential that the RPE system and its partners are able to effectively implement culturally-appropriate prevention strategies with the following selected populations indicated by the SPT’s needs assessment: marginalized racial/ethnic populations, people who are GLBT, Deaf people and people with disabilities, and faith communities.

**Goal 1: Increase the capacity of staff/volunteers, including agency leadership, at RPE-supported organizations and related SV and DV programs in Massachusetts to effectively engage selected populations in the primary prevention of sexual violence.**

**Objective 1.** By 2010, MDPH and JDI will develop and implement a needs assessment<sup>4</sup> that will identify the current competencies and practices of staff/volunteers at RPE-supported organizations and related SV and DV programs regarding prevention with selected

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<sup>4</sup> Recruit graduate intern.

populations as specified.<sup>5</sup> This needs assessment will also investigate respondents' understanding of, and ability to effectively utilize the intersectionality framework for sexual violence prevention.\*

**Proposed strategies:**

- (1) A series of facilitated meetings will be held with JDI-member programs to foster dialogue about the intersectionality of oppressions and its implications for the prevention of sexual violence. (RPE)
- (2) Survey of JDI member and DPH funded programs. (RPE)

**Objective 2.** By 2011, the MDPH and JDI will expand the capacity of staff/volunteers at RPE-supported organizations and related SV and DV programs to engage in the **planning, implementation, and evaluation of** primary prevention of sexual violence with selected populations.

**Strategies:**

- (1) JDI and DPH will provide technical assistance/training based on results of Objective 1 above (RPE)
- (2) Staff/volunteers at DPH-funded rape crisis centers will receive basic training from their RCC on primary prevention, utilizing standard JDI training curriculum (RPE)
- (3) 3 sites will receive technical assistance from Close To Home to enable implementation of culture-affirming, community organizing and youth engagement strategies
- (4) Promote the use of *Balancing Acts: Keeping Children Safe in Congregations*, online course for tools to prevent/address sexual abuse in Faith Communities, and coordinate RPE programming with DPH DV/SA in Faith Communities initiative.

**Goal 2: JDI and MDPH will provide leadership to support culturally relevant partnerships and expand state system capacity for sexual violence prevention, including the specific goals of this plan by\*:**

- **focusing public attention on the effective, culturally-relevant prevention of sexual violence perpetration;**
- **providing technical assistance to organizations whose engagement in the prevention of sexual violence will support this plan's goals and vision;**
- **fostering linkages between (and among) state agencies and partnerships/coalitions for the purpose of collaborating and capacity-building on sexual violence prevention initiatives (e.g., MATSA, MASOC, EOPS, EOHHS, EOE, Be SAFE, etc.)**

**Objective 1:** By 2011, state RPE staff will provide leadership for the MDPH healthy relationships/healthy sexuality workgroup to develop DPH-wide system capacity to address integration of healthy sexual behavior strategies.\*(RPE)

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<sup>5</sup> Selected populations for this objective include racial/ethnic populations, GLBT people, Deaf people and people with disabilities, and faith communities.

**Objective 2:** By 2011, in collaboration with JDI, a minimum of 2 MA RPE grantees will have partnered with MA news media to promote more positive and proactive interaction between journalists and sexual violence prevention advocates and promote accurate public awareness about sexual violence and sexual violence prevention in the media.\*

**Proposed strategy:** MDPH and JDI will host a regional Poynter Institute/NSVRC intensive training seminar for pairs of journalists and sexual violence prevention advocates or facilitate the participation of a minimum of 2 teams from MA in one of these trainings.

**Objective 3.** By 2012, MDPH and JDI will have increased statewide and local programs' RPE program evaluation capacity, with a focus on incorporating RPE indicators and measures.

**Proposed strategy:** DPH and JDI will utilize tools and technical assistance provided by CDC through its "Indicators and Measures" project to build statewide and local RPE systems' capacity to evaluate RPE programming. Corresponding contractual standards and trainings will be developed to support this objective.\* (RPE)

**Goal 3. Expand opportunities for male engagement in the promotion of positive models of manhood in all cultures and the prevention of sexual violence.<sup>6\*</sup>**

**Objective 1.** By 2011, increase the capacity of staff and consumers at 10% of MA programs focused on responsible masculinity to actively engage in the primary prevention of sexual violence\*

**Proposed Strategies:**

**(1)** Expand and institutionalize partnership of several Massachusetts-based organizations (including JDI, MDPH, CTF, Family Violence Prevention Fund, DOR, DCF) that have been collaborating to promote positive fathering, including support for fathers to promote their children's' development of healthy sexuality and relationships.

**(2)** As reflected in youth strategies above, JDI will collaborate with Father Friendly Initiative programs to provide educational sessions with fathers to strengthen these specific protective factors.\*(RPE)

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<sup>6</sup> This goal should result in culturally-specific strategies





## **B. Universal Population: Youth (children, adolescents, young adults)**

**Need:** Children, adolescents, and college students are at high risk for experiencing sexual assault (4, 44). As many as 20-33% of girls and 10-14% of boys are sexually abused before age 18 (44). It is estimated that between 30-50% of sexual abuse of children is perpetrated by other youth (24). Approximately 15-25% of U.S. college women have experienced SV, and Massachusetts is home to a proportionately large college population. Youth is a key period for development of relationship values, attitudes and behaviors. Therefore, there is a need to promote healthy, respectful relationship and sexuality norms—and behaviors—with children, adolescents, and young adults in Massachusetts.

### Notes:

- *Local communities will have the flexibility to identify locally-appropriate selected youth and/or youth-influencing organizations; state grant-making portfolio must ensure the culturally-specific inclusion of selected populations (3).*
- *Youth-related strategies must be attentive to working with adults to establish readiness in a community (e.g., school administrators, parents, etc.) in order to support, reinforce and sustain youth-focused work.*
- *Prioritize coordinated, effective entities and strategies for capacity-building/TA with youth-serving organizations. DPH should explore the possibility of creating a partnership to “co-hold” this section of plan with EOHHS and emerging Executive Office of Education*

**Goal 1. To promote healthy, respectful relationship and sexuality norms and behaviors for Massachusetts youth in preschool, elementary school, middle school, high school and college.\***

**Objective 1.** By 2011, at least 2,000 Massachusetts parents will have been exposed to at least one evidence-based or evidence-informed strategy that promotes parenting skills that strengthen children’s relationship-level risk and protective factors for sexual violence.<sup>7</sup>

### **Proposed Strategies**

- (1) Sexual Abuse Free Environment for Teens (SAFE-T) (RPE):** see description under schools objective below; though this strategy includes a parent component.
- (2) Understanding/Responding to Sexual Behaviors of Children (URSBC)\*:** 2 available training programs: (1) Enough Abuse campaign’s URSBC training sessions provided by Enough Abuse pilot site trainers, based on Gail Ryan/Prevent Child Abuse-VT. (2) On-line *Understanding Children’s Sexual Behaviors- From Natural and Healthy to Disturbed* training developed by Dr. Toni Cavanagh Johnson for NEARI.
- (3) Statewide Responsible Fatherhood initiative\*:** JDI will develop or adapt and implement a pilot training for Fatherhood Service providers on men’s engagement

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<sup>7</sup> The strategies used to meet this objective must include culturally-specific approaches for parents, and fathers in particular, of Latino/Hispanic, African-American/Black, and Portuguese-speaking youth, which may include the Massachusetts interagency healthy fathering group developing a new focus on sexual respect and healthy parenting.

in sexual violence prevention with support from DPH. This training will be piloted with specific fathering programs and evaluated for improvement with feedback from providers.

**Objective 2.** By 2011, MDPH will develop and implement a healthy sexuality education needs and resource assessment<sup>8</sup> specific to children and youth with physical, cognitive, sensory and mental health disabilities, and state-involved (DYS/DCF/DTA) youth.\*

**Objective 3.** By 2016, 20% of MA-licensed early childhood programs will implement evidence-informed strategies to increase protective factors and reduce risk factors for sexual violence perpetration in coordination with MA's existing child-focused risk reduction and abuse response programs.\*<sup>i</sup>

**Proposed Strategies**

**(1) Partner with MECCS** (MA Early Childhood Comprehensive Systems Project of DPH and DEEC) to incorporate into their parent support trainings of child care providers: (1) Preventing Child Sexual Abuse in Youth Serving Organizations (based on CDC publication of same name) and (2) *Understanding Children's Sexual Behaviors- From Natural and Healthy to Disturbed*

**Strategy information: Preventing Child Sexual Abuse in Youth Serving Organizations Initiative:**

This strategy, developed by SPT member Joan Tabachnick for the MA Enough Abuse campaign based on a 2008 CDC publication, is designed to change policy. It builds youth organizations' capacity to implement policies and skill building, including employee screening and supervision, training for staff (such as local Enough Abuse trainers and NEARI on-line training on Understanding Children's Sexual Behavior described under Objective 1), and maintaining safe environments.

**Objective 4.** By 2016, a minimum of 10 schools in Massachusetts, in partnership with local sexual/domestic violence programs, will implement evidence-informed programming to increase protective factors and reduce risk factors for sexual violence perpetration, in coordination with best-practice school administration policies, practices, and services for health education, risk reduction, and for youth with sexually abusive behavior problems and/or victimization histories.<sup>9\*</sup>(RPE)

**Proposed Strategies**

**(1) Preventing Child Sexual Abuse in Youth Serving Organizations** (see description above, under Objective 3).

**(2) Sexual Abuse Free Environment for Teens (SAFE-T):** This health education program for middle school students, developed by Prevent Child Abuse Vermont,

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<sup>8</sup> A statewide needs and resources assessment for healthy sexuality education of youth with disabilities will include the culture of youth communication methods, and will retain a youth empowerment focus promoting long-range development of leadership and culturing points of view for subsequent generations. SPT will pursue partnerships for development and analysis of this assessment and accompanying recommendations with Partners for Youth with Disabilities, Federation for Children with Special Needs, Massachusetts Advocacy Center, MASOC, GLBT youth groups, MSPCC and MRC "turning 22" groups. This assessment is currently under development.

<sup>9</sup> Among these strategies should be a media literacy and intersectionality strategy that will expand youth's ability to identify examples of racism, classism, ableism, sexism, transphobia, and homophobia in the media as well as identify examples that challenge these negative images. School strategies should also incorporate policies to appropriately respond to youth with sexual behavior problems and victimized youth.

promotes prevention by helping students to identify factors that put them at risk for being hurt and hurting others, while fostering the development of protective factors and resilience. Designed for implementation by teachers, the curriculum includes parent-specific interventions as well as media literacy training for youth. It has been evaluated using a quasi-experimental design.

**(3) Safe Dates:** SV prevention program identified by CDC as evidence-based and designed to stop or prevent the initiation of emotional, physical, and sexual abuse on dates or between individuals involved in a dating relationship. Intended for male and female 8th- and 9th-grade students, the goals of the program include: (1) changing adolescent dating violence and gender-role norms, (2) improving peer help-giving and dating conflict-resolution skills, (3) promoting victim and perpetrator beliefs in the need for help and seeking help through the community resources that provide it, and (4) decreasing dating abuse victimization and perpetration. Safe Dates consists of five components: a nine-session curriculum, a play script, a poster contest, parent materials, and a teacher training outline.

**(4) Men of Strength (MOST) Clubs/Men of Strength Campaigns:** MOST Clubs are unique in their focus on manhood. Each 16-session club explores how the role of traditional masculinity leads young men to make choices based on their understanding of what it means to be a "real" man - choices that often put themselves and women at risk. Sometimes implemented in conjunction with multi-media public education "Strength" campaign.

#### **Additional strategies that are currently being implemented in MA:**

- a. **Mentors in Violence Prevention:** Gender violence prevention program at Northeastern University that currently is active and used by multiple schools in Massachusetts. Currently receives state funding through DCF. Holds biannual trainings for those wishing to implement in schools.
- b. **DESE Training Initiative "Talking about Sex Safely" course for Classroom Health Teachers:** multi-day training that includes clarifying the language of human sexuality, addressing sexual health disparities by focusing on local community, and applying effective sex education models in Massachusetts classrooms by health education teachers.
- c. **Be SAFE:** a multi-year collaboration that focuses on youth and the interconnected issues of sexual and mental health; substance abuse; healthy relationships and sexual violence. Involves AIDS Action Committee, Planned Parenthood League of MA, BARCC (local RPE program), and several other partners. Potential systems capacity strategies with this emergent program include: a) training for youth b) training for professionals, etc.
- d. **Wellesley Centers for Women's Open Circles program:** "Open Circle is a comprehensive, grade-differentiated social and emotional learning program for grades K-5 children, their teachers, administrators, other school staff, parents and other caregivers... foster the development of relationships that support safe, caring and respectful learning communities of children and adults."<sup>10</sup> Open Circle will be integrating the

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<sup>10</sup> Taken from [www.open-circle.org/](http://www.open-circle.org/).

*BullyProof* curriculum into its program. Open Circle is currently being piloted in two schools in MA, with plans to have it in more of the Boston Public Schools.

**Objective 5.** By 2016, legislative and administrative advocacy and interagency and campus collaborations will result in MA universities and colleges having enhanced policies and programming supportive of sexual violence prevention, in coordination with campus and community-based victim services and RPE programs and pending legislation.

**Strategies: \***

- (1)** Achieve establishment of statewide campus violence prevention task force in MA that includes primary prevention of sexual violence.
- (2)** Build and grow support for college/community partnerships and implementation of evidence-informed SV prevention initiatives on college and university campuses. Consider emerging evaluations of MA campus-based initiatives such as the UMass Lowell bystander program.



## **C. Selected population: Gay, Lesbian, Bisexual, and Transgender (GLBT) people**

**Need:** GLBT people are at increased risk for sexual violence victimization as compared to their heterosexual counterparts. A recent DPH analysis of 2001-2006 BRFSS data also indicates GLB disparities: 13% of straight/heterosexual, 26% of gay/lesbian/homosexual, and 37% of bisexual adults reported ever being sexually assaulted. These populations face additional barriers to receiving necessary services and benefiting from prevention programming. In order to improve our state's ability to prevent the perpetration of sexual violence against GLBT people, we need to prepare MDPH-funded programs to engage in this work. Furthermore, we need to collect more and better quality data about the sexual violence victimization experiences of GLBT people in order to inform prevention programming.

**Goal 1. Increase the capacity of programs that serve GLBT populations to understand and prevent sexual violence.\***

**Objective 1.** By 2012, 50% of requests for responses (RFRs) from the Community Health Access and Promotion, HIV/AIDS, Substance Abuse and Communicable Disease Bureaus of DPH, will include language that specifies that providers will be trained on the trauma-informed prevention of sexual violence inclusive of GLBT-specific focus. Additionally, applicants will document explicit collaborative agreements with sexual assault programs for all populations including GLBT individuals.\*

### **Proposed strategies**

- (1)** Use cross-DPH healthy sexuality/relationships working group to initiate contract language and training content and implementation, in coordination with EOHHS trauma-informed care working group, GCASDV systems integration workgroup, and appropriate consultant(s). Training development should build on specialized GLBT program expertise on GLBT cultural competence (e.g., HCSEMA) and violence prevention/services (e.g., The Network/La Red)
- (2)** Use Adult Learning Principles (e.g., CDC's guidelines for RPE professional trainings, which are based in this literature) to conduct provider trainings.

**Goal 2. To gather more and better quality information about sexual assault against GLBT people, and share that information for program improvement purposes, across prevention-related initiatives and agencies.**

**Objective 2.** By 2016, MDPH will have created a partnership to complete one assessment of the nature and consequences of sexual violence victimization against GLBT people in Massachusetts. Of specific importance will be to investigate (a) the relationship between victim and perpetrator; and (b) the context of the assault(s).\*



## **D. Selected population: People with disabilities**

**Need:** According to the majority of published reports, individuals with disabilities are more likely than those in the general population to experience sexual assault victimization (20). For adults with developmental disabilities, the reported rate of sexual assault is 4-10 times greater than among other adults (21). In Massachusetts, there is a need to increase understanding of healthy sexuality and healthy sexual behaviors among youth and adults with developmental disabilities, and to improve the environments in which people with developmental disabilities live, work, and recreate so that they support these healthy behaviors.

**Goal 1: Increase capacity of DDS service system for the promotion of healthy sexuality and relationships among people with developmental disabilities and their service systems. This will support the Department of Developmental Services' (DDS's) existing human rights policy that adult clients have the right to "intimate relationships with mutually consenting adults" and "to be free from harm or abuse."**

**Objective 1.** By 2009, DDS, in consultation with DPH and DPPC, will develop and implement a needs and resource assessment with the DDS vendor network to identify healthy sexuality/relationship education, practices/policies and tools for DDS vendors' staff and adult clients

*(Note: This survey will include a question on vendor policies/practices requiring waiting periods for new hires prior to their providing intimate personal care for clients. DDS will also assist with the distribution of DPH's cross-disabilities youth-focused needs/resource assessment to its youth-focused networks—see youth population goal, objective 2)*

**Objective 2.** By 2010, DDS, DPH and DPPC will create additional opportunities for cross-training (e.g., joint provider meetings, focus at statewide Human Rights conference, etc.) to build DDS providers' and DPH RCC/Family Planning providers' capacity for the promotion of healthy sexuality/relationships among people with developmental disabilities.\*

**Objective 3.** By 2011, DDS, DPH, and DPPC will incorporate evidence-informed strategies for promotion of healthy sexuality/relationships into their educational programs for adults with developmental disabilities, including the Building Partnerships Initiative peer education program.\*

**Objective 4.** By 2012, DDS will consider expansion of its standards related to healthy sexual decision making (e.g., skills for understanding consent in oneself and in others) as part of its broader revision of annual Individual Service Plan process for its clients.\*



*Contingent on future findings of needs/resources assessment, DDS will explore the possibility of the following recommendations already received from key informants:*

- *Provide annual opportunities for approved, evidence-informed healthy sexuality certification trainings for all vendors who require it*
- *If applicable to the population served by specific vendors, require them to have an identified, certified, DD-specific sexuality educator*
- *Provide a list of recommended or required evidence-informed curricula and qualified trainers on healthy sexuality/relationships and sexual abuse prevention*
- *Provide sample client assessment tools specific to ability to consent to provider network*
- *Require or recommend that new hires have a specific “waiting period” prior to being assigned/allowed to do intimate personal care for clients.*



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## **APPENDICES**

### **APPENDIX A:      Acronyms**

- CTF: Children's Trust Fund- quasi-governmental children's advocacy organization; funds parenting and fatherhood programming
- DCF: Department of Children and Families (formerly DSS)- state agency, funds domestic violence programs, among other obligations (state child protective services agencies)
- DDS: Department of Developmental Services (formerly DMR)- state agency, funds residential programs and other services for people with developmental disabilities
- DEEC: Department of Early Education and Care (formerly OCCS)- state agency that licenses early education and care and after-school time programs, among other obligations
- DESE: Department of Elementary and Secondary Education (formerly DOE)- state agency overseeing elementary, middle, and high schools/school districts
- DHE: Department of Higher Education (formerly BHE)- state agency overseeing colleges and universities in the state higher education system
- DOC: Department of Corrections – state agency overseeing state prison system and related adult correctional programs
- DOE: former Department of Education, now Department of Elementary and Secondary Education
- DOR: Department of Revenue
- DMR: former Department of Mental Retardation, now Department of Developmental Services (see above)
- DPH: Department of Public Health – state public health agency that includes oversight and funding of rape crisis centers and administers the EMPOWER and RPE programs, among others
- DPPC: Disabled Persons Protection Commission- state agency overseeing rights and violation of rights of persons with disabilities in MA
- DSS: former Department of Social Services, now Department of Children and Families (see above)
- DYS: Department of Youth Services- state agency overseeing corrections for youth
- EOE: Executive Office of Education- state secretariat overseeing DEEC, DESE, and DHE

EOHHS: Executive Office of Health and Human Services- state secretariat overseeing DMH, DDS, DCF, DPH, DYS and numerous other state agencies

EOPS: Executive Office of Public Safety – state secretariat overseeing DOC, State Police, SORB, and other state public safety agencies

GCSDV: Governor’s Council Addressing Sexual and Domestic Violence

IPV: Intimate Partner Violence- used by the CDC, some hospitals, and some researchers, often in place of the term “domestic violence,” though some definitions of IPV and DV differ

JDI: Jane Doe Inc., the Massachusetts Coalition Against Sexual Assault and Domestic Violence- state coalition representing programs that work on sexual and domestic violence issues

MASOC: Massachusetts Adolescent Sexual Offender Coalition- coalition of professionals committed to stopping sexual abuse through early and specialized intervention, assessment, treatment and management in the lives of sexually abusive children and youth.

MATSA: Massachusetts Association for the Treatment of Sexual Abusers- multi-disciplinary organization committed to the prevention of sexual assault through effective management of sex offenders

MCC: Massachusetts Citizens for Children- children's advocacy organization; state Prevent Child Abuse Massachusetts chapter

MCSAPP: Massachusetts Child Sexual Abuse Prevention Partnership: Coalition of agency working to prevent child sexual abuse. Received funding from the CDC resulting in Enough Abuse campaign.

MCSOM: Massachusetts Coalition for Sex Offender Management- association of agencies, including DPH, DOC, Probation, Parole, Sex Offender Registry Board, and Jane Doe, Inc.

MECCS: Massachusetts Early Childhood Comprehensive Systems Project- CDC-funded DPH project; works both within and outside the Department of Public Health to coordinate services for young children birth to five. Target areas include: Access to health insurance and medical homes, Social-emotional development and mental health, Early Care and Education, Parenting Education, and Family Support

MVP: Mentors in Violence Prevention- DCF-funded program at Northeastern University works statewide at addressing men's violence against women with high school students through a bystander curriculum.

MCYVP: Massachusetts Coalition for Youth Violence Prevention

NEARI: New England Adolescent Research Institute

NSVRC: National Sexual Violence Resource Center

RCC: Rape Crisis Center (a.k.a. sexual assault prevention and survivor services contract)- one of 17 vendors that meet DPH criteria for sexual assault prevention and survivor services and have a contract to provide specific services (see SAPSS below)

RISE: Refugee and Immigrant Safety and Empowerment Program

SAAB: Sexual Assault Advisory Board- Provides input to Jane Doe Inc. on sexual violence-related issues.

Safe Spaces for GLBT Youth - DPH program providing support for Gay, Lesbian, Bisexual, and Transgender youth

SANE: Sexual Assault Nurse Examiner program

SAPSS: Sexual Assault Prevention and Survivor Services program- DPH program; Director Marci Diamond, staff: Janice Mirabassi, Mark Bergeron-Naper

SORB: Sex Offender Registry Board

SV: Sexual violence includes sexual harassment, sexual threats or intimidation, rape, attempted rape, incest, sexual assault by a current or former spouse, boyfriend or girlfriend, child sexual abuse, sexual exploitation, sexual trafficking, stalking, and other forms of unwelcome or coerced sexualized acts. Sexual violence can but does not always include physical violence or other non-sexual contact

VAWA: Violence Against Women Act- federal act that has funding allocations attached to it that several MA agencies receive, including DPH, EOPS, and DCF



## APPENDIX B:

## Glossary

**Comprehensive:** Prevention strategies will be “packaged” in a comprehensive way within a community, together with competent services related to risk-reduction (e.g., Child Abuse Prevention Program, Talking About Touching, self-defense/empowerment programs), victimization (e.g., trauma-sensitive schools initiatives, trauma-informed care trainings, rape crisis centers, Child Advocacy Centers, trauma-sensitive schools) and abusive behavior (e.g., specialized referral, assessment and treatment for children with sexual behavior problems) response. Implementation of this plan should consider prioritizing funding in communities with readiness to approach prevention in a comprehensive manner, and to developing readiness with adults in a community to support youth-focused work.

**Culturally-Relevant Fit, Inclusion, Community Ownership, Community Knowledge, Social Justice:** Because culture is central to prevention and evidence indicates that “one size fits all” approached tend to be less effective, strategies utilized to meet the goals in this plan must include culturally-specific approaches for populations that have borne a disproportionate burden of sexual violence and that been historically underserved. These strategies must be developed by/with the specified populations.

**Intersectionality of oppressions:** “Intersectionality of oppressions” is defined as the ways in which various socially and culturally constructed categories interact on multiple levels to create inequalities in society. Intersectionality holds that oppressions within society, such as those based on race/ethnicity, gender, religion, nationality, sexual orientation, class, or disability do not act independently of one another; instead, these forms of oppression interrelate creating a system of oppression that reflects the “intersection” of multiple forms of discrimination. These concepts are especially important in the development and implementation of prevention initiatives as they directly connect to the theories of causality, contribute to a broader understanding of the implications of strategies, and impact outcomes in terms of ensuring that stereotypes and misconceptions are not promoted. Given that sexual and domestic violence have complex dynamics and impact populations in different ways, an understanding of the intersections of oppression is critical in developing approaches that are guided and informed by diverse people.

**Sexual violence:** Any sexual activity where consent is not obtained or able to be freely given.

**Sustainability/accountability:** We recommend an ongoing collaborative, multidisciplinary group to take responsibility for these goals and be accountable for them (e.g., ongoing SPT).

**Trauma-informed prevention:** Prevention strategies must be based in an understanding that any population selected for prevention activities will include people who have already experienced sexual abuse or who have abused others. Prevention programs will therefore take conscious steps to avoid re-traumatizing, victim blaming, or colluding with abusive behavior/attitudes. They should also ensure that those delivering prevention activities have sufficient knowledge, skills, and connection to specialized assessment and treatment services to be effective bridges to services when disclosures do occur.

## APPENDIX C: State Demographics Profile\*

\*All data from U.S. Census, 2000 unless otherwise specified

State: Massachusetts

Source of data: Multiple Year: Various

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Community type: Urban 84.3% Rural 15.7% Suburban     

Geographic size: 7,840 square miles

Source of data: U.S. Census Bureau Year: 1990 (Community type) and 2005  
(Geographic size)

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### Total population

Unemployment rate: National 4.6% State 5.1%

Undocumented labor: National NA State NA

Per capita income (annual): National \$25,035 State \$31,007

Families below poverty level (%): National 10.2% State 7.3%

Individuals below poverty level (%): National 13.3% State 10.3%

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### Age distribution in years

National		
Age	%	No.
<5	7.0	
5-14	14%	
15-24	14%	
25-64	54%	
≥ 65	11%	
Total population:		296,410,404

State		
Age	%	No.
<5	6.4	395,070
5-14	13%	800,039
15-24	12%	744,491
25-64	57%	3,446,452
≥ 65	11%	693,132
Total population:		6,182,860

## Homelessness

On March 20, 1990, the US Census attempted to count the US homeless population in certain locations. There was a great deal of criticism of the methodology, but here are the figures reported. Source: "Fact Sheet for 1990 Decennial Census Counts of Persons in Selected Locations Where Homeless Persons Are Found." Washington, DC: US Bureau of the Census, nd. In Jacquelyn Quiram, et al. *Homeless in America*. Wylie, TX: Information Plus, 1997. These include individuals in homeless shelters, domestic violence shelters, visible on the street, youth shelters, shelters for unwed mothers, group homes for mentally ill, group homes for substance abuse, farm dorms, and other.

Nation: 459,215 (0.2%)

Massachusetts: 11,533 (0.2%)

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### Annual household income

Amount	National		State	
	%	No.	%	No.
< \$15,000:	15%	16,499,002	14%	332,491
\$15,000-\$24,999:	12%	13,286,246	9%	225,458
\$25,000-\$49,999:	27%	29,497,173	21%	511,556
\$50,000+:	47%	51,808,196	56%	1,378,527

Massachusetts median household income: \$57,184

U.S. median household income: \$46,242

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### Incarcerated

Federal: 2,186,230 Rate: 443 per 100,000

State: 22,778 Rate: 356 per 100,000

Source of data: Bureau of Justice Statistics\* Year: 2006

\*Inmates in custody of state or federal prisons or local jails as of June 30, 2005, and the number of inmates per 100,000 residents. Population Includes unconvicted inmates.

### Massachusetts Nursing Home Beds

Number: 50,794

Beds per 1000, age 65+: 62.7

### Marital status:

(for people age 15 years old and older)

51% of females in the U.S. are married and 56% of males in the U.S. are married.

49% of females in MA are married and 55% of males in MA are married.

Other **Marriage Data**

**Table 1.** Number of marriage records received by the Massachusetts Registry of Vital Records and Statistics from May 17, 2004 through May 5, 2006 by year.

Year	Male/Female	Male/Male	Female/Female	Total
2004	27,196	2,166	3,929	33,291
2005	36,141	720	1,302	38,163
2006	3,999	24	30	4,053
Total	67,336	2,910	5,261	75,507

The numbers for 2005 and 2006 are preliminary and subject to change. City and town clerks are not required to transmit records to the state Registry until the 10th day of the second month following the date of marriage. Despite best efforts, transmittal of records from cities and towns to the state is not always timely. The preliminary totals included in this table reflect records that have been received and reviewed by the state Registry.

Source of data: MDPH Registry of Vital Records Years: 2004-2006

**Sexual Orientation Data (from MA BRFSS—draft data, do not distribute)**

	Heterosexual		Gay or Lesbian		Bisexual		Other	
	N	% (95% CI)	N	% (95% CI)	N	% (95% CI)	N	% (95% CI)
<b>Overall</b>	29,596	96.7 (96.4-97.0)	751	1.9 (1.7-2.0)	283	1.0 (0.8-1.2)	160	0.4 (0.3-0.6)
<b>Sex</b>								
male	12,126	96.8 (96.3-97.2)	409	2.1 (1.9-2.4)	96	0.7 (0.5-1.0)	66	0.4 (0.3-0.6)
female	17,470	96.7 (96.3-97.1)	342	1.6 (1.4-1.8)	187	1.2 (1.0-1.5)	94	0.5 (0.3-0.6)

**Gender**

	<u>Number</u>	<u>%</u>
Female:	3,184,822	51.5
Male:	2,998,038	48.5
F to M:	Need data	
M to F:	Need data	
Transgender:	Need data	

Source of data: US Census Year: 2005

According to data from the 2004 American Community Survey, an estimated 764,000 people in Massachusetts have a disability, translating into 13.2% of the population age 5 and over. An estimated 127,000 people, or 2.2% of the population, have difficulty performing self-care activities, also known as Activities of Daily Living.

Source of data: American Community Survey\_\_\_\_\_ Year: 2004\_\_\_\_\_

Number: 784,484                      %: 13.6

Source of data: US Census      Year: 2005

	No.	%
White:	5,156,426	83.4
Black:	363,095	5.9
Hispanic*:	490,839	7.9
American Indian+:	13,708	0.2
Asian#:	292,537	4.7
“Some other race”:	269,564	4.4

Source of data: US Census Year: 2005

Number of person currently enrolled:

	National	State
Elementary/Middle school	<u>32,556,000</u>	<u>582,539</u>
High school	<u>16,791,000</u>	<u>296,511</u>
Alternative Schools		

Technical school	_____	_____
College	<u>17,383,000</u>	<u>398,142</u>

Source of data: U.S. Department of Education, National Center for Education Statistics, Common Core of Data (CCD), "State Nonfiscal Survey of Public Elementary/Secondary Education" Year: 1999–2000

Educational achievement (# of adults 25 years and over who completed):

	<b>National</b>	<b>State</b>
Elementary school plus some high school	<u>17,989,278</u>	<u>298,648</u>
High school	<u>55,856,936</u>	<u>1,164,066</u>
Technical school	_____	_____
College: some college	<u>37,984,610</u>	<u>678,365</u>
4 years	<u>32,536,186</u>	<u>895,971</u>
≥ 5 years	_____	_____

Source of data: U.S. Census Bureau Year: 2005

## **APPENDIX D: Disabled Persons Protection Commission Data**

Date: May 16, 2007

To: Susan Love

From: Emil DeRiggi

Re: DPH Request for Information

Attached is information you requested on behalf of DPH from the DPPC Intake Database. I have attempted to follow the criteria they provided as closely as possible, but it is imperative to remember that the database used to retrieve this information was not created for the purpose of research. The primary function of the DPPC Intake Database is to record information related to abuse reports made to the DPPC Hotline; and to allow for the dissemination of this information throughout the 19C adult protective service system. As a result there are inherent limitations when extracting data from the database. Regarding the data DPH requested:

- DPPC accepts and documents all abuse reports made to the DPPC Hotline without judgment regarding the accuracy or validity of the information provided. Only through the investigation process is information verified. Therefore, much of the information in the DPPC Intake Database is unverified and should be considered as such.
- The data in the DPPC Intake Database is fluid and changes daily; therefore, data extracted one day may differ from data extracted on another day. This is the result of case related information being added as it is received. There is less fluidity in older cases.
- Data regarding the number of substantiated investigations are accurate as of the day the data is extracted from the database and will change as more investigations are completed and investigation reports submitted. This is especially true when extracting information regarding recently reported allegations of abuse.
- Victims identified in the complaints provided for this request of information were reported to have a specific disability by the person making the report to the DPPC hotline. Except for those reports that were investigated under the authority of 19C, there has been no verification of this information by DPPC.
- Victims identified in complaints made to the DPPC hotline may be reported to possess more than one form of disability, therefore the total number of complaints and the total number of types of disability will differ.
- DPPC maintains a continuous quality improvement environment and as a result the DPPC databases are updated frequently to enhance how they aid in achieving the overall mission of the DPPC. At times these improvements impact the information that is retrievable from the database; and this is true for some of the data requested by DPH.

<b>Reports to the DPPC Hotline by Disability Involving Sexual Allegations</b>		
<b>Fiscal Year 2005</b>		
	Total Reports	Number Substantiated
Mental Retardation	272	23
Mental Illness	270	15
Cerebral Palsy	15	1
Multiple Sclerosis	4	1
Mobility Issues	63	8
Alzheimer's Disease	1	0
Head Injury	13	4
Visually Impaired	11	1
Seizure Disorder	12	2
Hearing Impaired	19	1

<b>Reports to the DPPC Hotline by Disability Involving Sexual Allegations</b>		
<b>Fiscal Year 2006</b>		
	Total Reports	Number Substantiated
Mental Retardation	241	16
Mental Illness	247	11
Cerebral Palsy	23	2
Multiple Sclerosis	1	0
Mobility Issues	44	9
Alzheimer's Disease	2	0
Head Injury	6	1
Visually Impaired	7	0
Seizure Disorder	18	1
Hearing Impaired	17	1

<b>Reports to the DPPC Hotline by Disability Involving Sexual Allegations</b>		
<b>Fiscal Year 2007</b>		
	Total Reports	Number Substantiated
Mental Retardation	241	8
Mental Illness	256	16
Cerebral Palsy	19	0
Multiple Sclerosis	0	0
Mobility Issues	60	5
Alzheimer's Disease	6	1
Head Injury	11	2
Visually Impaired	8	1
Seizure Disorder	34	2
Hearing Impaired	8	0

<b>Reports from the DPPC by disability regarding Sexual Allegations and Criminal Charges</b>
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<b>Fiscal Year 2007</b>				
	<b>Sexual Assault</b>		<b>Rape</b>	
	Cases referred to the DA's office	Cases where criminal charges were filed	Cases referred to the DA's office	Cases where criminal charges were filed
Mental Retardation	55	11	57	9
Mental Illness	24	4	73	3
Mobility Issues	6	0	24	4
<b>Totals</b>	<b>85</b>	<b>15</b>	<b>154</b>	<b>16</b>

<b>Reports from the DPPC by disability regarding Sexual Allegations and Criminal Charges</b>				
<b>Fiscal Year 2008</b>				
	<b>Sexual Assault</b>		<b>Rape</b>	
	Cases referred to the DA's office	Cases where criminal charges were filed	Cases referred to the DA's office	Cases where criminal charges were filed
Mental Retardation	58	5	73	7
Mental Illness	51	12	76	8
Mobility Issues	6	2	8	0
<b>Totals</b>	<b>115</b>	<b>19</b>	<b>157</b>	<b>15</b>

## **APPENDIX E: Survey Methodology, Materials, and Results**

SPT members themselves were among the respondents to these surveys, based on their current role (e.g., some SPT members who are current RPE providers, completed that survey, while those who were not RPE providers were asked to complete the service provider survey).

Massachusetts' wealth of activist organizations was likewise considered an important strength. Massachusetts has many established *statewide* coalitions and organizations already committed to and supportive of prevention activities, and many that are explicitly working on issues of violence (e.g. child sexual abuse and exploitation, sexual and domestic violence, youth violence).

These include but are not limited to:

- Jane Doe Inc.: The MA Coalition Against Sexual and Domestic Violence (and its Sexual Assault Advisory Board)
- MA Youth Violence Prevention Coalition
- MA Coalition for Sex Offender Management, MA Association for the Treatment of Sexual Abusers, MA Adolescent Sexual Offender Coalition and EOPS<sup>11</sup> Sex Offender Management Collaborative Project
- Coalition of MA Certified Batterer Intervention Programs
- Employers Against Domestic Violence
- Governor's Commission on Sexual and Domestic Violence
- EMPOWER State Prevention Team (SPT)
- MA Child Sexual Abuse Prevention Partnership/Enough Abuse Campaign
- Trafficking Victims Outreach Services (TVOS) Coalition
- MA Children's Alliance (CACs<sup>12</sup>) and Pediatric SANE<sup>13</sup> Partnership
- Llámanos: Statewide Spanish-Language Sexual Assault Helpline

### **Survey Specific Summaries**

#### **Survey 1: Service providers**

The service provider survey link was emailed throughout Massachusetts to non-RPE sexual assault, domestic violence, batterer intervention, sex offender management, GLBT-specific, child abuse, substance abuse, HIV, STD, disabilities advocacy, family planning, immigrant and refugee, human trafficking, prostitution, and youth violence programs and coalitions.

150 professionals responded.

- 61% work in the area of sexual and domestic violence prevention,
- 45% in HIV/AIDS prevention

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<sup>11</sup> EOPS: Massachusetts Executive Office of Public Safety

<sup>12</sup> CAC: Children's Advocacy Centers

<sup>13</sup> SANE: Sexual Assault Nurse Examiner

- 35% in substance abuse prevention
- 29% in youth violence prevention
- 29% in child abuse prevention
- 25% in family planning
- 14% in prevention of abuse with persons with disabilities.

Most respondents indicated that their organizations were committed to, supportive of, and knowledgeable about prevention activities and dedicate personnel and financial resources to sexual violence prevention. About half work in organizations where staff sees prevention of SV as an essential part of their work.

These service providers indicated that there is limited regular discussion of sexual violence prevention at their organizations' staff meetings and that organizational leadership could play a larger role in supporting primary prevention through fundraising and building community commitment.

Existing prevention strategies used included:

- 70% professional training
- 51% educating non-professionals (e.g., general public, students, etc.)
- 44% policy-development and change
- 39% community organizing

Respondents identified a wide range of professionals (e.g., health care, law enforcement, child protection, educators, and social services) and community members (children, youth, elders, culturally-specific groups) as intended audiences for these activities.

Topics addressed in prevention activities included healthy relationships, gender, bystanders' behavior, sexual health, policy development, and specific forms of violence (e.g., child sexual abuse, dating violence, trafficking, prostitution, domestic violence, hate crimes, GLBT domestic violence/sexual assault, racism).

66% respondents were involved in coalitions to prevent sexual violence. 86% of those who were not yet involved wanted to be. These providers felt they needed more information about SV and existing coalition work, an invitation, financial resources, and/or assurance of coalition's cultural competency and strategic value.

Most respondents' agencies do not receive any specific funding for SV prevention or did not respond to funding questions. The 5 that did said that they receive between \$5,000 and \$50,000 for this work

#### Survey 2: FY07 MDPH Rape Prevention Education (RPE) Grantees' survey

The federally-funded Rape Prevention Education Program administered by the MDPH currently supports 19 contracts to plan and implement sexual violence prevention activities. 2 are statewide (Jane Doe Inc. and Llámanos) , and the remainder are based out of local rape crisis centers.

16 of 19 (84%) of the MDPH-funded RPE providers responded to survey, including both statewide programs and 14 local programs.

The majority of RPE providers indicated full organizational commitment to prevention. Some indicated “limited” organizational knowledge of prevention activities, discussion of SV in staff meetings and commitment to evaluation.

The RPE programs employ primary prevention strategies at varying levels of the social-ecological model based upon goals set out in their contractual requirements. The tables below highlight focused work with two communities: indigenous people and faith-based populations.

Focus - Indigenous Community (Visioning BEAR Circle)	
Individual	Sacred circle discussions of healthy relationships based on indigenous cultural traditions will decrease individual participants' acceptance of rigid gender roles and sexual preference.
Relational	An inter-generational elder mentoring program that teaches the younger members of the community about healthy relationships based on indigenous cultural traditions
Community	Tabling, drumming and participating in Pow Wows will increase community awareness of Circle and provide forum for community-wide engagement in SV prevention work
Societal	Circle will work with local RCC staff to address policy changes related to Indigenous community

Focus - Faith Community	
Individual	Increase capacity by church staff and volunteers to recognize and interrupt potentially sexually abusive behaviors in teens and adults
Relational	Discussions and sermons addressing sexual and domestic violence during worship services will encourage congregants to discuss healthy relationships and intervene when witnessing potentially abusive behavior
Community	Annual distribution and discussion of safe church policies will change congregation norms around recognizing and intervening in potentially abusive behaviors of teens and adults in the congregation
Societal	

Current prevention strategies named in the survey were: professional training, policy development, public education, campus and school based education, social norms work, and community organizing and development.

Intended audiences noted in the survey included: men and boys, clinicians, college students, middle and high school students, pre-school community, sexual and domestic violence program staff, at-risk/out-of-school youth, immigrants, young parents, DYS system, Latino community

Topics indicated by RPE survey respondents included: men's engagement, primary prevention framework, trauma-informed response, bystander intervention skills, healthy/unhealthy relationships, child sexual assault prevention, gender stereotypes, boundaries and consent, gender myths and equality, communications skills, conflict resolution, healthy sexuality, sexual respect, self-esteem, negotiation skills.

Most RPE respondents indicated focusing on both perpetration and victimization prevention (i.e., focusing on preventing a person from perpetrating sexual violence and preventing a person from being a victim of sexual violence). Most also indicated their strategies involved a series of sessions, but many also sometimes utilized single sessions. One program that was using single sessions indicated it is currently working to develop a multi-session curriculum.

The Massachusetts Department of Public Health has developed and implemented contractual pre-service training standards for all RPE grantee prevention educators, to support the principle of well-trained staff. In addition to the minimum 35 hours of rape crisis counselor training, all RPE grantee prevention staff must receive additional training on:

- CDC/DPH framework for the primary prevention of sexual assault
- Youth and adult development and learning styles
- Public speaking and varied, participatory methods
- Specific prevention and professional training programs and/or curricula to be implemented
- Responding to disclosures in the context of prevention and making internal and external referrals
- Prevention program data collection and record-keeping

However, survey respondents documented little detail on actual training provided to the staff/volunteers that deliver specific RPE activities, and even less information was noted on evaluation of these strategies. Some of the programs indicated that the people at their agencies who deliver SV prevention strategies are trained in presentation skills, specific curricula, community organizing, social norms, and/or working with systems. One indicated use of a specific evaluation/assessment method, namely a tool from the University of New Hampshire.

Little information was noted by survey respondents on evaluation of RPE strategies. Some of the programs indicated that the people at their agencies who deliver SV prevention strategies are trained in presentation skills, specific curricula, community organizing, social norms, and/or working with systems. One indicated use of a specific evaluation/assessment method, namely a tool from the University of New Hampshire.

Most RPE programs reported that they currently participate in coalitions to prevent sexual violence. Two that did not, said they would, if they had more information and financial resources for travel/staffing.

### Survey 3: Personal resources survey

Those who received provider or RPE surveys were also asked to complete and distribute a personal resources survey to fellow community members such as constituents, clients, students, and colleagues.

A total of 93 people responded. 42% were from the Boston area and between 11-12% were from either Central MA, Western MA, or Southeast MA. Respondents were between 25 years and 71 years old with equal proportions of people in each age bracket. The majority of respondents were women, were White, and were heterosexual. Many people identified their age as a very important personal identity factor in their lives. Many were domestic violence or sexual assault service providers.

The survey asked about where and with whom respondents and the people they know talk about “issues” in their lives. This was designed to see if there was a difference in where people talked about general “issues” vs. talking about sexual violence. It also indicates existing areas of strengths/assets that could be built upon to prevent sexual violence.

Respondents indicated that people in their lives talk about issues with co-workers, friends and family, in settings such as the kitchen table, coffee shops, internet, children’s bus pick-up point, and community meetings.

Respondents indicated that they talked about sexual violence:

- with friends and family
- at work (keep in mind that many respondents said they worked at sexual and/or domestic violence programs)
- “at the kitchen table,” (i.e., at home)
- with community groups and organizations such as neighborhood associations, crimewatch groups, book clubs, faith community
- via the internet (including for people who didn’t generally feel safe talking)
- in trusted community groups (such as the Network/La Red, and RPE programs)
- when prompted by media or in reaction to an incident or a movie
- in academic communities

Many people mentioned that they did not talk about or did not feel safe talking about sexual assault.

For help with issues in their personal lives, respondents reported turning to spouses, partners, friends, family, colleagues, experts, therapists and the internet, depending on whether they were looking for information or personal support.

Strategies used for preventing sexual violence included participation in:

- talking about sexual violence with their colleagues, children, friends, and/or young people in their lives

- professional work (counseling, law enforcement, training, etc)
- volunteering
- SV seminar/training events
- religious community
- book groups
- self-defense classes
- neighborhood groups

Several people indicated their own personal qualities (setting an example, making life decisions, using buddy systems, setting personal boundaries and avoiding risky situations) as ways they try to prevent sexual violence in their daily lives.

The majority of respondents promote healthy relationships and sexual non-violence at work and some said that this was the only place where they could or did talk about sexual violence, which may reflect the selection bias of this survey. People also promoted healthy relationships and sexual non-violence by talking to partners, setting a positive example, and participating in community events.

Respondents noted concerns about privacy issues, and also suggest “a lot of silence” about sexual violence. In order to be more effective at participating in sexual violence prevention, respondents felt they and their communities needed:

- training on how to talk about sexual violence and how to be an activist (i.e., being OK with uncomfortable situations or starting conversations)
- more skills
- more male, peer, family, partner, court support for having these types of conversations
- printed materials
- better media
- opportunities to get together in neighborhood
- access to schools
- safe, GLBT friendly spaces
- greater understanding of all forms of oppression
- more contacts with service providers/resources (and more services, such as a statewide hotline for SV, internet listed on MA resources, materials)
- integration of SV into other issues like worker rights

Important resources for sexual violence prevention that were reported included Jane Doe, RCCs, the Network, DPH, health care providers, friends, and other formal and informal resources.

Respondents felt it would also be important to also involve the media, liquor/bar associations, labor unions, schools, media, men, immigrants, people of color, GLBT folks, various professions (police, medical), youth, church, businesses, sports teams, community groups and leaders, government, artists (musicians, writers), and survivors in sexual violence prevention. Community spaces (schools, safe space settings, and clubs) were emphasized.

In Fall 2007, an additional web-based survey was conducted by advocates in Massachusetts with a wide range of stakeholders within the disability rights movement and sexual and domestic violence movements and related public and private agencies. While the survey was not focused on prevention assets specifically, several findings were especially relevant to prevention planning:

92% percent of survey respondents agreed that “special sexual assault programs at the community level with uniquely trained staff that focus solely on serving deaf and disabled people” was an area in need of a lot of or drastic improvement. 71% agreed that fewer needs were more important and that creating such programs with specially trained staff should be an immediate priority or that this need was important and should be addressed in the short-term.

Similarly, 92% agreed that “cross-training between sexual assault service providers and service providers who work with deaf and disabled people” was in need of a lot of or drastic improvement. 74% percent agreed that there were few needs more important and that this should be an immediate priority or that it was critical and in need of being addressed in the short-term.



## **APPENDIX F: Barriers to Primary Prevention in MA**

Some barriers to sexual violence prevention in MA were noted in response to the assets assessment described earlier in this report. However, after reviewing the results of the assets report, the SPT felt it was important to also specifically assess barriers. The SPT Barriers Workgroup was therefore convened to conduct an additional survey with the diverse members of the State Prevention Team.

Frequently cited barriers included:

- data collection: lack of uniform collection methods, difficulty distinguishing incidence rates from reporting rates, lack of data on certain populations, and the multiple barriers survivors face in reporting that hinder development of accurate profiles of perpetrators
  - a need for improved prevention strategies: a lack of proven methods or culturally relevant resources, etc. and
  - Organizational collaboration (e.g., infighting over resources, deterrents to inter-organizational collaboration).
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